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ABSTRACT

This monograph contains a study conducted by the Population Division of the United Nations Economic and Social Committee for Asia and the Pacific (ESCAP). The document is designed to aid policy-makers, administrators and evaluation personnel in family planning programs in the ESCAP region, primarily; and researchers working in the field of family planning program evaluation. The main objective of the study is to examine the existing family planning service statistics systems in the region from the points of view of uniformity in the definitions of key terms and concepts used in program evaluation and the capabilities of the systems to generate and process reliable data required for program evaluation and monitoring. Most of the data were gathered through the administration of an open-ended questionnaire and through personal visits to the study countries by the staff of the ESCAP secretariat. Contents written in this report include topics related to the main objective of the study. There are ten annexes that contain data, records, and reports. A short bibliography concludes the document. (Author/MA)

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A COMPARATIVE STUDY OF FAMILY PLANNING SERVICE STATISTICS SYSTEMS IN THE ESCAP REGION

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ASIAN POPULATION STUDIES SERIES
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A COMPARATIVE STUDY OF FAMILY PLANNING SERVICE STATISTICS SYSTEMS IN THE ESCAP REGION

ECONOMIC AND SOCIAL COMMISSION FOR ASIA AND THE PACIFIC
Bangkok, Thailand
1975

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PREFACE

This study was conducted by the Population Division of ESCAP in collaboration with 11 countries of the region: Fiji, Hong Kong, India, Indonesia, Malaysia, Nepal, the Philippines, the Republic of Korea, Singapore, Sri Lanka and Thailand. The main objective of the study was to examine the existing family planning service statistics systems in the region from the points of view of uniformity in the definitions of key terms and concepts used in programme evaluation and the capabilities of the systems to generate and process reliable data required for programme evaluation and monitoring. Most of the data were gathered through the administration of an open-ended questionnaire and through personal visits to the study countries by the staff of the ESCAP secretariat.

Mr. Walter B. Watson of the Population Council, New York, assisted the secretariat in the capacity of a consultant in preparing the project proposal and the study questionnaire. Mr. P. S. Mohapatra co-ordinated the study with the assistance of Miss Amy H. C. Ong. The national counterparts from the participating countries were Mr. John G. Cleland (Fiji), Mr. K. C. Chan (Hong Kong), Mr. K. C. Seal (India), Miss S. O. Djajanegara (Indonesia), Mr. Tan Boon Ann (Malaysia), Mr. P. L. Joshi (Nepal), Col. Juan M. Sanchez (Philippines), Dr. Kyong-Shik Chang (Republic of Korea), Dr. Chen Ai Ju (Singapore), Dr. R.A.S. Rabel (Sri Lanka), Dr. Winich Asavasena (Thailand), and Dr. Chaichana Suvanavejh (Thailand), who furnished the information required for the study and also wrote reports on the family planning service statistics systems of their respective national programmes.

It is hoped that this monograph will be useful to policy-makers, administrators and evaluation personnel in family planning programmes in the ESCAP region as well as outside the region, and to researchers working in the field of family planning programme evaluation.

22 August 1975

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I. ORGANIZATION OF THE STUDY

A. Introduction

1. The growing realization on the part of national Governments of the inhibiting influences of unchecked population growth on social and economic development led to the emergence of nation-wide family planning programmes in most of the developing countries of the ESCAP region during the 1960s and the early 1970s. Developments in contraceptive technology during the last decade and the availability of large-scale international assistance in terms of financial resources have played key roles during this period. Almost all Governments with national policies and programmes in the ESCAP region view the reduction of marital fertility as an essential factor in the solution of the population problem. This reduction could be best achieved through the voluntary postponement or limitation of the number of children by means of various methods of contraception.

2. The formulation and implementation of national family planning programmes have aimed at educating couples in modern methods of contraception, creating group acceptance and support for the small family norm, and providing supplies and services needed by couples in an acceptable manner. Most national family planning programmes have laid down specific goals for the reduction of marital fertility measured by a given number of points of birth rates or growth rates within a given time limit and have developed elaborate networks for family planning education and services. Where these goals have been fixed, targets have been worked out in terms of the number of accepters of the different family planning methods that should be recruited by the programme from year to year or within a broad time period. Demographic goals and corresponding acceptance targets have varied from country to country and have been revised over time in the light of accumulating experience; but generally, the national family planning programmes have tended to be time-bound and target-oriented.

3. In such a context, the evaluation of these family planning programmes has become an essential operation for policy-makers and programme administrators to ensure that their programmes are implemented efficiently and reach the goals set for them. Whenever the goals set for different phases of programme achievement have not been realized, the problems have been analysed, leading either to modification or expansion of the programmes to achieve the goals or else the goals have been revised to realistic levels.

4. In order to provide assistance in monitoring its progress, each programme has almost invariably started with a built-in evaluation apparatus. However, the appropriate development of this apparatus to suit the programme needs has generally lagged behind that of the programme implementation mechanism, especially during the early years. The rapidly growing investment of resources in terms of finance, deployed personnel and physical facilities in the family planning programmes and the establishment of nation-wide networks of service facilities have made the evaluation and management aspects of programme implementation increasingly important with the passage of time. The need for relatively accurate data on programme operations and achievement is felt more keenly now than ever before.

5. A major part of this built-in evaluation apparatus is concerned with the "system of collection, compilation and analysis of routinely generated data for efficient and effective planning and operation of the programme", a system which is variously referred to as a "management information system", a "recording and reporting system" and a "service statistics system". (The last description was adopted for the purposes of this report.) This system remains the main source of information on programme inputs and achievement. The extent to which it has been able to provide programme administrators and evaluators with the information required for efficient programme implementation and to maintain flexibility in coping with changing data needs has been observed to vary from one programme to another.

6. Designing an appropriate system for service statistics requires a foreknowledge of the procedures and types of data involved in the collection and analysis. Most family planning programmes went through a stage of experimentation with different procedures and record forms during the initial years of development; sometimes they were assisted by local representatives of international donor agencies. As more countries around the world initiated national family planning programmes, research institutions and organizations also began to show considerable interest in suggesting service statistics systems for general application and they suggested advantages of certain types of records and reports. One technical aid, *A Handbook*

for Service Statistics in Family Planning Programmes[1], offered guidelines for the day-to-day collection of statistics. The principal record suggested in this handbook was the coupon, which had earlier been proposed by Tietze[2]. The coupon was basically a form on which client-processing information could be incorporated.

7. Attention was also directed towards the type and quality of evaluation efforts for measuring programme achievements. Manuals developed by Bogue[3], Pedersen *et al*[4]. and Reynolds[5] suggested several models for evaluation frameworks at different programme levels. In addition, the evaluation process was reviewed. Corsa[6] emphasized the need to evaluate the ultimate output of programmes in terms of births prevented, the financial inputs into the programmes and the principal ingredient of the programmes - the staff. Reynolds placed emphasis on other areas: "to develop clear concepts and to define key terms, to improve existing data collection and analysis procedures, to refine survey instruments, to refine and validate measurements, and especially to design, test and install evaluative systems and to conduct evaluative studies that will provide information that can be used to improve family planning programmes"[7].

1/ J.A. Ross, F.F. Stephan and W.B. Watson, *A Handbook for Service Statistics in Family Planning Programmes* (New York, The Population Council, Inc., 1968).

2/ Christopher Tietze, "Records and records keeping in family planning program", in *Family Planning and Population Programs: A Review of World Development* Chicago, The University of Chicago Press, 1966).

3/ Donald J. Bogue, ed., *Family Planning Improvement Through Evaluation: A Manual of Basic Principles* (Chicago, The Community and Family Study Center, University of Chicago, 1970).

4/ H. Pedersen, H. Flkins and J. Sinquefield, *A Simplified Client Record System for Family Planning Programs*, (Chicago, The Community and Family Study Center, University of Chicago, 1972).

5/ Jack Reynolds, Manuals for Evaluation of Family Planning and Population Programmes: *A Framework for the Selection of Family Planning Evaluation Topics* (No. 1), *A Framework for the Design of Family Planning Program Evaluation Systems* (No. 2), *A Method for Estimating Future Caseloads of Family Planning Programs* (No. 3), and *Operational Evaluation of Family Planning Programs through Process Analysis* (No. 4) (New York, Division for Programme Development and Evaluation International Institute for the Study of Human Reproduction, Columbia University, 1970).

6/ Leslie Corsa, Jr., "Family planning evaluation", in the *Proceedings of the Combined Conference on Evaluation of Malaysia National Family Planning Programme and East Asian Population Programmes*, Dewan Tunku Abdul Rahman, Kuala Lumpur, 18-25 March 1970, p. 67.

7/ Jack Reynolds, "Evaluation of family planning program performance: a critical review", *Demography*, 9 (1) (February 1972), p. 83.

8. The past ESCAP effort in this direction was to convene several meetings of programme evaluation personnel in the region. Recommendations from three meetings[8,9,10] have outlined the regional needs for the objective assessment of programme performance. Another in a series of expert group meetings focused its attention on cost-effectiveness aspects of family planning programmes[11]. In at least two of the meetings, the discussion called for the clarification of certain terms and concepts often used in programme evaluation, and suggestions were made for the possible uses of service statistics as well as other types of data for programme evaluation. The recommendations made at these meetings helped to define the long-term plan for ESCAP assistance to member countries' programmes through regional studies, training programmes, expert group meetings and regional seminars. This study, which was the first in a series of regional and subregional study projects concerning family planning to be undertaken by ESCAP, was an effort to look closely at the existing service statistics systems of a large number of national programmes of the region, against the background of the over-all programme structure in each country.

B. Objectives

9. The objective of the present study is to examine the existing service statistics systems from the points of view of (a) uniformity of the definitions of key terms and concepts used in programme evaluation and (b) the capabilities of the systems to generate and process reliable data required for monitoring programme progress and depicting programme effectiveness and efficiency on a continuous basis. A related objective involves gathering information on the availability of relevant data for developing simple indices, which could be easily understood and interpreted by programme administrators. The data on various family planning programmes which were assembled to achieve the objectives include:

8/ United Nations, *Assessment of Acceptance and Effectiveness of Family Planning Methods* (United Nations publication, sales No. E. 69. II. F. 15.)

9/ United Nations, *Evaluation of Family Planning Programmes* (United Nations publication, sales No. E. 70. II. F. 20).

10/ United Nations, *Administrative Aspects of Family Planning Programmes* (United Nations publication, sales No. 66. II. F. 10).

11/ United Nations, *Socio-economic Returns of Family Planning Programmes*, Report of an Expert Group Meeting, Asian Population Studies Series No. 12, (E/CN 11/1070).

(a) Policies, organization and functioning, and operational targets;
(b) Organization and administration of the evaluation unit (s);
(c) Evaluative criteria, terminology, procedures, and feedback system; and
(d) Sources and nature of data collected and processed with emphasis on programme input and output data generated through the service statistics and budgetary systems.

10. With regard to uniformity in the definitions of key terms and concepts, it was not intended to develop a set of standard definitions and recommend them for consistent use in all programmes. It was recognized that the usage of particular terms was influenced by the relevant programme context in each individual country. A comparative analysis of the definitions used in the study countries was therefore attempted, from which the commonalities underlying these definitions could be gleaned, despite the differences in their programme contexts.

11. The service statistics systems integrate the information required to evaluate programme performance, although they themselves are not causally involved in the programme achievements. The records and reports might be seen as catalytic elements of the system, in that, while they did not themselves affect programme performance, they were responsible for the composition and quality of the data from which programme performance was measured. Thus, the procedures governing the format, content number and movement of forms are critical factors in planning for an efficient and effective flow of information. The purpose of this study is to examine in detail those existing components of the information flow system and their utilization in the study countries.

12. It should be mentioned that this study was not intended to be a comparative evaluation of family planning programme effectiveness in the countries of the region. Rather, it was hoped that the presentation of a detailed description of service statistics systems in the region would pave the way for a regional or sub-regional assessment of programme operations and more effective family planning programme evaluation systems.

C. Operational procedures

13. In 1971 ESCAP commissioned a proposal and a design for the study which was discussed in a meeting of selected experts in April 1971 and finalized later that year. Eleven countries of the ESCAP region which have national family planning programmes participated in the project, namely, Fiji, Hong Kong, India, Indonesia, Malaysia, Nepal, the Philippines, the Republic of Korea, Singapore, Sri Lanka and Thailand. In most countries the chiefs of the central evaluation units of the respective programmes served as the national counterparts (hereinafter referred to as country co-ordinators) for the study.

14. The study focused on data generated through service statistics systems rather than on other sources of data used in family planning programme evaluation (e.g., vital statistics, census and special surveys). It dealt not only with the service statistics themselves but also with the processes by which they were generated. The flow of data from the peripheral unit to the central evaluation unit, their analysis and publication were considered, as well as the functioning of the programme evaluation unit or units in the collection, processing and communication of data to administrators and field personnel.

15. A detailed questionnaire (annex I) covering seven major areas of programme administration was constructed and forwarded in July 1972 to the co-ordinators in the countries participating in the study. Information was sought regarding their national family planning programme's background, including its organization and personnel, its targets, and budget and finance arrangements. Definitions of a few terms and concepts used frequently in the programme and information on their evaluation unit and service statistics system provided the bulk of the data used in this study.

16. The country co-ordinators were also requested to prepare a comprehensive report on the family planning service statistics systems in their respective countries observing an outline (annex II) provided to them in October 1972. The outline was designed to retrieve more specific information on the system itself and to elicit less formally an assessment of the service statistics system's abilities to meet programme needs as seen by each country co-ordinator.

17. The replies to these questionnaires were compiled, tabulated and analysed in the documents appended to this report. Before being assembled in the final version, the tabulated information was corroborated by the co ordinators at a meeting held at Bangkok from 2 to 7 April 1973. This meeting was able to adopt a more analytical and self-critical approach to service statistics systems. The discussions revealed

different perspectives on several problems underlying the administration of a service statistics system as well as a certain amount of consensus on possible solutions.

18. A draft report of the study, based on the data thus collected, was sent to the country co-ordinators for their comments and suggestions in order to ensure that the information it contained was accurate and up-to-date. The present report has incorporated the factual alterations and additions suggested by the country co-ordinators and has been updated to 1 January 1974.

19. In order to appreciate the dynamics of a service statistics system, it is necessary to be familiar with some of the programme features and the existing variations and problems. In this report, therefore, before analysing the service statistics systems, the organizational elements of the programmes are discussed (chapter II), followed by definitions of terms and concepts used in programme operation and evaluation (chapter III). The latter reveals the variations in terminology that confronted attempts at comparative evaluation. Chapters IV and V deal with the components of the service statistics systems, and chapter VI presents discussions of a few issues related to service statistics systems. These issues are the maintenance of the quality of the statistics, the computerization of the system and the integration of service statistics with health statistics. It was felt that this sequence of discussion would be appropriate for examining the service statistics systems.

II. ORGANIZATIONAL PATTERNS OF NATIONAL FAMILY PLANNING PROGRAMMES

20. A multitude of factors, e.g., social, economic, political and others, could influence the nature of a national family planning programme, its implementation strategy and its success in gaining acceptance. High levels of socio-economic development are known to be conducive to acceptance of small family-size norms and practice of family planning methods. The countries under study varied considerably with respect to several key socio-economic indicators, data on some of which are available in the Population Council's "Population and family planning programmes: a factbook" [1]. There were, however, a few other more closely related variables that directly affected the scope of programme operations. Some of these will be discussed in this chapter, in addition to a few major factors contributing to the internal variations in programme structure.

A. Factors affecting the scope of programme operations

21. Several external factors influenced the size and composition of the population being served by a national programme at each level down to the clinics at the peripheral level. The geographic conditions of a country affected the nature of the outreach efforts of the service staff. In dispersed areas, such as the Philippines and Nepal, target couples were less accessible, while concentrated regions, such as Hong Kong and Singapore, needed other adjustments in the scope of the programme operations. In addition, the urban and rural distributions of the eligible or target population implied different consumption levels and mobilization of the programme resources.

22. Among the ecological considerations, the density of the service area was foremost. Areas of high density with varying proportions of eligible women defined the caseloads for the clinics and motivational teams. These caseloads were, in turn, reflected in the levels of administration for supplies and supervision. Ultimately, the intensity of programme efforts had to take these immutable factors into account.

23. Demographic factors were also in play. The lowering of birth rates, partially attributed to programme successes, brought about modifications in programme strategies designed to reach certain specific sectors of the community. In some countries, such as Singapore, the programmes specifically sought to increase acceptance rates among certain eligible groups of women who were known to be resistant to the adoption of family planning. Continuing high death rates in other countries retarded the acceptance of small family-size norms and required intensified health inputs, particularly in maternal and child health (MCH), in order to expand contraceptive practice.

24. While population variables could modify the operational nature of a programme, it was their interaction with other determinants that sometimes influenced the scope of the programme. In this context, the roles of (a) the voluntary organizations, (b) the commercial sector and (c) private doctors in expanding the public's practice of contraception were among the major factors that contoured the activities of a national programme. These factors will be discussed in the following paragraphs.

(a) Voluntary organizations

25. In all countries studied, family planning had been pioneered by voluntary agencies, almost invariably affiliated with the International Planned Parenthood Federation (IPPF). Voluntary agencies often enjoyed a more efficient organization and tighter supervision, partly because of their unofficial nature. They were often able to implement innovative campaigns in much less time than the government programmes. In several places, such as Fiji, Hong Kong and the Republic of Korea, the voluntary organizations were responsible for information, education, communication and other motivational activities. In Indonesia, the Planned Parenthood Association carried out a substantial amount of training activities. The national programmes were thus relieved of a considerable workload and possible political repercussions were averted. Frequently, the major agencies carried the name Family Planning Association, and one such organization affiliated with IPPF existed in each of the study countries.

26. With the establishment of large-scale networks of service outlets in the government programmes, the voluntary associations gradually had diminished roles in the provision of services. With the exception of

1/ D. Nortman, "Population and family planning programmes: a factbook", *Reports on Population/Family Planning* (New York, The Population Council, September, 1972).

Singapore and Fiji, however, they continued to operate *bona fide* clinics, mainly in the urban areas. In many countries they received some financial or other assistance from the national Government, and their proportional contribution to total accepter recruitment was substantial in at least two countries, Malaysia and the Philippines. In Hong Kong the majority of the accepters had been recruited by a voluntary organization. Several Indian voluntary organizations operated family planning clinics and recruited a significant number of accepters although the number was small in a proportion to total accepters. Furthermore, in Indonesia and Malaysia where the government programmes were limited to Java, Bali and West Malaysia respectively, voluntary agencies operated clinics outside of these areas.

27. Where a co-ordinating board had been established as part of the national policy, as in Indonesia, Malaysia and the Philippines, voluntary organizations became implementing agencies for family planning services. Although their clinics remained under the direct supervision of the mother institutions, their servicing procedures were overseen and even regulated by the national board. Even in countries where the government programme was administered by the respective health ministries, the work of voluntary associations was coming more and more under government scrutiny and co-ordination.

28. Voluntary organizations had unquestionably been largely responsible for creating climates favourable to the adoption of large-scale family planning programmes. An Expert Group Meeting on the Role of Voluntary Organizations in National Family Planning Programmes convened by ESCAP at Bangkok from 7 to 12 August 1972, agreed "that the responsibilities which the voluntary organizations carry would vary from country to country, depending upon the experience" and that "governments should assume responsibility for routine service functions leaving the voluntary organizations the responsibility to fill gaps in the government programme, initiate new activities and develop methodology" [2]. It is foreseeable that the activities of voluntary organizations will be limited more to providing model clinics that stress efficiency and effectiveness rather than quantitative expansion.

2/ United Nations, *The Role of Voluntary Organizations in National Family Planning Programmes*, Report of an Expert Group Meeting, Asian Population Studies Series No. 13, Bangkok, 1973, p. 5.

(b) Commercial sector

29. The extent of non-programme family planning practice also became increasingly prominent as another factor that governed the scope of programme operations. Over-the-counter sales of conventional contraceptives and oral pills were estimated to cover a separate but sizable group of the eligible population in many countries. The accessibility, availability and convenience of commercial purchases often supplied the desired anonymity as well as a choice of methods to persons unable or unwilling to attend clinics for one reason or another.

30. The private medical sector had begun to play a greater role in family planning during the last several years, particularly in the urban areas. Although IUD insertions were done under the sponsorship of the government programmes, whether by doctors employed in the programme or otherwise, private doctors were free in most countries to prescribe oral pills or perform steriliaation operations. Extra-legal induced abortions were prevalent to a greater or lesser extent in all countries, provided mainly by private practitioners. Although the extent is not precisely known, abortions have had a considerable impact on fertility in some countries such as the Republic of Korea, where they have been used more than any single method of contraception. With the liberalization of abortion laws, as in India and Singapore, private practitioners are likely to be more involved in the future.

31. Data available on family planning acceptance outside the national programme have been of mixed quality in terms of reliability and completeness. By and large, the voluntary associations reported acceptance figures to the national family planning service statistics system, although the regularity and completeness of reporting varied from one country to another. With the increasing co-ordination of their activities by national programme authorities, this situation can be expected to improve.

32. Most programme evaluators were quick to admit a lack of information on how extensively commercial sales figured in total family planning practice. Recently, however, several programmes took the initial steps to circulate forms to pharmacists and pharmaceutical suppliers in order to monitor the sales activity (e.g., Malaysia, Repulic of Korea and Singapore); this attempt at monitoring was anticipated to continue in the future on an annual basis. Fiji had been more successful in systematically supervising the commercial distribution

of condoms and pills, and India received figures regularly for the Nirodh marketing programme, the largest single organization offering condoms for sale in the market in that country. Indonesia and Thailand collected such data on an *ad hoc* basis, but for other research purposes. Even so, the magnitude of non-programme contraceptive use had not been accurately known in most countries.

(c) Private practitioners

33. Even less was known about the magnitude of the contributions of private practitioners. Attempts were made in Malaysia to obtain acceptance statistics from certain private doctors who were designated to prescribe and supply pills at subsidized prices, by requiring them to report on a simplified form. The services of private doctors linked up with monetary compensations as in the Repulic of Korea (IUD insertions and sterilizations) or India (sterilization) had a higher probability of being reported, but this might not always be the case if the amount of compensation was considered to be insignificant by the doctor. Only Singapore systematically received data on induced abortions.

34. Ignorance about the segment of the population protected outside the government programme reduced the comprehensive picture of total family planning practice. Singapore estimated that 75 per cent of the women practising family planning were covered by programme reporting. However, estimates were not available from other countries.

The absence of precise data on this segment was not yet a serious impediment in most countries; but with the increasing contributions of the non-programme sector, more precise information would be required regularly in order to adjust programme goals accordingly. The evaluation of the effectiveness of a family planning programme would be more meaningful when comparable figures on acceptance of family planning through non-programme sources became available.

B. Variations in programme organizations.

35. Considerable variation was seen with regard to (a) the location of the policy-making authority; (b) the agencies responsible for programme implementation; (c) the state of integration with health and other services; and (d) the number of administrative hierarchies in the programme. An attempt is made below to arrive at some broad classifications.

(a) Location of policy-making authority

36. With respect to policy-making authority, the various programme organizations were dichotomized into: (i) those which were subsumed under the ministry of health in the respective countries and (ii) those which were independent of the bureaucratic structure of any of the ministries. Programmes and policy-making bodies in Fiji, India, the Republic of Korea Sri Lanka and Thailand were part of the ministries of health, although variations existed in the extent to which family planning had a separate identity under the health umbrella in these countries. In addition, in Singapore the family planning policies were made by the Singapore Family Planning and Population Board, which was a statutory board under the Ministry of Health. Nepal's Family Planning and Maternal and Child Health Project had the Director General of Health Services as the Chairman of the Project's Co-ordinating Committee. As mentioned earlier, the responsibility for the programmes in the Philippines, Indonesia and Malaysia was given to specially constituted autonomous bodies which appeared to have greater flexibility of operations within the approved budget. Hong Kong was the only country where the national programme was administered by a voluntary organization with considerable government support but without its direct control (as of December 1972).

(b) Programme implementation responsibility

37. Where the national board was independent of the health ministry the major field activities, i.e., the delivery of services and motivational efforts were undertaken by implementing agencies whose work was co-ordinated and evaluated at the national level by the board, which provided the logistics and financial support. Thus, the Population Commission of the Philippines and the National Family Planning Co-ordinating Board of Indonesia primarily co-ordinated the work of the various implementing agencies, including the Department of Health [3]. The National Family Planning Board in Malaysia implemented a part of the service programme in addition to providing co-ordination, evaluation and logistics support to the other implementing agencies. In contrast, where the family planning organization was part of the health ministry, the programme was implemented at the field level mainly through the existing health infrastructure although the

3/ In Indonesia, however, the Ministry of Health operated 80 per cent of the clinics. In the Philippines, a little over half the clinics belonged to the Department of Health.

extent of utilization of this infrastructure for family planning activities varied a great deal among the countries. In these countries also the efforts of voluntary associations engaged in family planning work were generally co-ordinated by the family planning authorities.

38. One exception to the latter group was India, where the Department of Family Planning at the central level had a co-ordinating function. The health ministries in the state governments, as well as several central ministries, implemented the family planning programme with 100 per cent financial support from the national Government. Furthermore, while the various implementing agencies in Malaysia, Indonesia and the Philippines operated clinics within the same administrative region, in India the territorial jurisdiction of each state provided immediate administrative demarcation.

39. In table 1 a broad cross-classification is provided of the 11 family planning programmes under study according to the locations of their policy-making authorities and their implementing responsibilities.

Table 1

PROGRAMMES CLASSIFIED ACCORDING TO LOCATION OF POLICY-MAKING AUTHORITY AND IMPLEMENTING RESPONSIBILITY

Location	Responsibility	
	Mainly co-ordinating	Mainly implementing
Outside health ministry	Philippines, Indonesia, Malaysia[a]	Hong Kong
Within health ministry	India	Fiji, Nepal, Republic of Korea, Singapore, Sri Lanka, Thailand

a. While the clinics of the National Family Planning Board of Malaysia recruited more than 60 per cent of the total accepters at present, the role of the Board in the near future is seen as mainly co-ordination; other agencies will expand their activities in delivering services.

(c) Integration with health and other services

40. The level of integration of family planning programmes with maternal and child health (MCH) and other health services might be seen from the point of view of functional integration in terms of use of common facilities, delivery of service, use of health workers for accepter recruitment, recording and reporting systems, etc., with or without administrative integration. Strictly speaking, many programmes did not qualify as being integrated, mainly because voluntary associations for family planning which were often implementing agencies of the programme did not generally provide any other services. Also, some categories of workers appointed for family planning in government programmes did not contribute to any of the health services. However, most programmes in the region might be said to be functionally integrated with MCH or general health programmes in one or more of the aspects mentioned earlier. All family planning programmes had taken advantage of the existing network for health services to a greater or lesser extent.

41. The administrative integration of family planning with MCH was more difficult to pin-point, even in programmes run by the health ministries. Family planning programmes in Fiji, Nepal, Sri Lanka and Thailand appeared to be most closely integrated with MCH services, both administratively and functionally. Further discussions on the subject of integration are found later in this report.

(d) Administrative hierachies in the programme

42. For family planning programme implementation, one or more intermediate supervisory levels between the clinic or the health centre and the national organization existed in all programmes except those in Hong Kong and Singapore, where population size and geographic area were small enough to render the multi-level system unnecessary, and in the Malaysian National Family Planning Board's service programme, which was mainly confined to urban areas.

C. Programme targets

43. With respect to programme objectives and targets, broad similarities as well as underlying differences were seen among the countries studied. All programmes under study, except those in Hong Kong, were based on officially declared policies of the concerned Governments. With the exception of another three (the Philippines, Singapore and Sri Lanka), the family planning programme goals were part of national development plans. All programmes, except those in Hong Kong and Sri Lanka, were economically goal-oriented in their ultimate programme objectives and aiming at increased economic standards of living.

44. Demographic targets for family planning programmes in the study countries and the methods of their determination are briefly presented in annex III. Data on recent acceptance targets and achievements are presented in tables 2 and 3. The methods for determining the targets varied considerably, but generally involved calculating the number of births that needed to be prevented, which was estimated from the desired reduction in birth rates by a certain time [4]. Then the number of accepters or users needed to "prevent" these births was determined and the final target number was set after further consideration of programme capabilities.

45. Generally, the programmes' acceptance targets were achieved with some notable overachievements, as in Indonesia and Thailand. The official target, established at the national level, filtered down to the field-worker level, further shaping the programme's character and performance. Achievement against target provided a basis for assessment. The fixed target system, such as in the Republic of Korea, could possibly stifle overachievement because of the predetermined budgetary allotments per recruited accepter. Increased inputs of service and motivational activities did not evolve more output since achievement at best equalled the target. Lethargy could occur when targets were achieved long before their annual dead-line, and no modifications could be instated rapidly enough. The degree of flexibility in target-setting with the reinforcement of a strong supervisory apparatus therefore constituted a singularly important dimension of a programme's structure.

46. A method-specific breakdown was often built into a programme's accepter target. Depending upon the supply of contraceptives, the popularity of an individual method and often the clinic staff's personal preferences, certain methods dominated the acceptance patterns. For example, the oral pill prevailed in Hong Kong, Malaysia, the Philippines and Thailand, the IUD in the Republic of Korea and condoms and sterilizations in India. While these acceptance patterns might reflect a method's acceptability, programme resources nevertheless adapted themselves to the trends and the method's prominence was perpetuated. Overemphasis of one method inevitably influenced the nature of the delivery service, the frequency and completeness of follow-up activities and ultimately the continuation rates.

47. Perhaps the critically important problem in evaluating programme effectiveness was the determination of the extent of contraceptive use. Together with this problem it was necessary to define acceptance and what degree of commitment to the practice of family planning it assured. Obviously, with permanent sterilization this question was unnecessary. However, the importance of calculating continuation rates for the oral pill and IUD was reflected in the increasing number of follow-up surveys. Thus, among the evaluation efforts was the implicit question of actual use in order to estimate the number of births averted or to note any declines in the fertility levels that could be attributed to a programme's presence. Examining a programme's operating concepts and terms could provide an idea of the programme's capabilities for self-evaluation, particularly with regard to its classification of accepters. Data on subsequent use would depend upon the validity of these efforts.

48. As mentioned in chapter I, a fairly comprehensive questionnaire was used in this study eliciting information not only on the programme evaluation systems in the study countries, but also on the programmes themselves. The latter was useful for understanding the dynamics of the programmes, which was essential for a proper examination of the relevant service statistics systems. In this chapter, only a few of the aspects concerning the programmes themselves were discussed. Data on several other programme elements such as personnel, budget, fees, incentives and programme achievement are not presented in this report since such information is readily available in other publications, such as the Population Council's "Factbook"[5].

4/ The actual procedure used in deriving annual acceptance targets from long-term demographic targets appeared to have serious shortcomings in several countries from the points of view of both data and methodology, although continuous efforts were being made to remove them. The importance given by national family planning programmes to improve target-setting procedures is evidenced from the fact that in 1974 eight of the study countries (all except Fiji, Hong Kong and Sri Lanka), as well as Bangladesh, Iran and Pakistan, had expressed interest in participating in an ESCAP study on target-setting methodology.

5/ D. Nortman, *op. cit.*

TABLE 2

METHOD-SPECIFIC ACCEPTANCE TARGETS

Country	Year	Total	IUD	Oral pills	Sterilization	Condom	Other methods
Fiji		No targets are set.					
Hong Kong*	1973 1974	33,000 33,000					
India	1972/73 1973/74	10,903,810 7,239,170	949,240 668,950		5,697,070 2,267,520	4,257,500 4,302,700	
Indonesia*	1972/73 1973/74	1,000,000 1,250,000					
Malaysia*	1973 1974	107,000 125,000					
Nepal*	1972/73 1973/74	60,000 80,000					
Philippines*	1973 1974	665,300 781,088					
Republic of Korea	1973 1974	720,000 817,000	300,000 380,000	250,000 250,000	20,000 37,000	150,000 150,000	
Singapore*	1973 1974	16,000 16,000					
Sri Lanka	1973 1974	not available					
Thailand	1973 1974	400,000 405,000	90,000 90,000	280,000 280,000	30,000 35,000		

* Method specific targets are not set for Hong Kong, Indonesia, Malaysia, Nepal, Philippines, and Singapore.

TABLE 3
NUMBER OF ACCEPTERS BY CONTRACEPTIVE METHODS

Country	Year	Total	IUD	Oral pills	Sterilization	Condom	Other methods*
Fiji	1972 1973	31,579 30,400	7,818 7,368	11,263 8,442	7,752 10,783	4,746 3,807	–
Hong Kong	1973 1974	33,043 29,802	481 283	24,293 20,604	517 722	5,838 5,610	2,114 2,583
India	1972/73 1973/74	5,862,480 4,311,173	353,149 367,179	–	3,121,426 934,851	2,387,905 3,009,143	–
Indonesia	1972/73 1973/74	1,078,889 1,369,077	380,253 293,171	607,050 857,700	–	77,418 210,551	14,168 7,655
Malaysia	1973 1974	57,312 61,680	906 801	49,881 55,723	4,109 4,142	2,106 2,546	310 468
Nepal	1972/73 1973/74	65,095 86,079	607 862	24,056 27,166	4,719 5,976	35,713 52,075	–
Philippines	1973 1974	737,933 729,133	100,875 72,556	406,970 355,837	–	138,710 197,624	91,279 103,116
Republic of Korea	1973 1974	761,095 800,574	325,875 350,459	234,698 241,958	24,490 35,254	176,032 172,903	–
Singapore	1972 1973	23,941 28,432	177 143	9,670 10,739	6,175 9,330	7,343 7,884	576 336
Sri Lanka	1973 1974	NA NA	27,528 29,693	NA NA	20,298 42,234	NA NA	NA NA
Thailand	1973 1974	422,176 494,479	93,449 89,739	268,674 305,244	49,606 80,482	–	10,447 19,014 (incl. Condom)

* "Other methods" include conventional contraceptives other than Condoms and are sometimes shown together with Condom. In the Philippines rhythm acceptors and in Thailand accepters of Depo-provera form a large proposition of "other methods" accepters.

III. DEFINITIONS OF TERMS AND CONCEPTS

49. The ESCAP Expert Group report on the "Assessment of acceptance and effectiveness of family planning methods" (1968) recommended definitions of four major terms used for evaluation purposes: "acceptance", "user", "continuation" and "effectiveness". A year later the report of a Regional Seminar on "Evaluation of family planning programmes" used the 1968 discussions as a basis for further clarification of the terminology. Other endeavours in this area were also undertaken by the World Health Organization and a Committee on Terminology of the National Family Planning Forum [1]. Efforts to compile a set of standardized definitions of terms and concepts used in family planning programme operations were not lacking, but consensus remained elusive. It was not unexpected that the use of these terms should vary among the programmes. However, for the purposes of interprogramme comparisons, standardization of the terms would be of considerable use.

50. The intention of this study with regard to standardizing definitions was not to produce a glossary of terms. In fact, it was recognized that a glossary would be of little practical use to the programmes. What was projected was a comparative analysis to extract and outline the common elements of the definitions of each term. The result of this attempt at standardization resembles a "least common denominator" of sorts, and the deviation of each country definition from it can be seen (annex IV). This annex shows whether a programme's use of a particular term was relatively more or less complex.

51. Since the terms covered a variety of programme features, it was apparent that even this attempt at standardization would have limited use. Although a standard wording was derived, representing as much consensus as was possible to extract from the definitions used in the countries under study, some programmes might not be able to alter their present usages to conform to these. However, these attempts at standardization were not meant to imply a need for conformity. It was obvious that not all programmes could modify their use of the terms without requiring concomitant changes in the programme structure, since the context of each programme largely affected its use. For example, the term "clinic" represented static features of a programme that involved the mobilization of certain personnel for certain times in certain buildings to provide certain services. Because the make-up of the personnel, the service locations and the services themselves all varied by programmes, naturally the connotations of the term "clinic" varied as well.

52. The question remained - - whom did a standardized definition serve? As an answer, this study held as one objective the provision of an overview of terms that would: (i) illustrate the variations that prevailed among them, their subterms and uses; and (ii) demonstrate the need for clarifying certain terms. Ultimatety, it was hoped that this objective would portray the situation of programme terminology as one that could benefit from further elaboration. This would be particularly important for a regional assessment of programme achievements. In this latter regard, terms for acceptance statuses, e.g., accepter, user, new accepter and dropout, required more specific definitions. As the question of use-effectiveness and extended use-effectiveness of family planning methods became more imminent in the evaluation of programme performance, the different types of accepters as well as those discontinuing their use of contraception had to be spelt out more clearly. Evaluating acceptance figures comparatively would have more meaning and relative value if the qualifications for being an accepter (or being a user) were uniform among the national family planning programmes.

53. The types of terms and concepts presented here were selected from among 18 or so that were to be defined by the country co-ordinators. In this study the co-ordinators had been requested to provide the programme definitions, if available, or their interpretations of the terms that were commonly used by their programmes. Definitions of other terms relevant to the programme, but not included in the questionnaire, could be added. These terms were broadly classified under several headings: the service context, the workers and the acceptance.

54. In some cases, it was not possible to apply the "least common denominator" technique, since several terms did not require or could not be reduced to a set of common elements. For example, country definitions of the terms "information/education/communication media" (IEC) were composed mainly of examples of

1 A forum comprising United States public and private family planning agencies. See "A family planning glossary" *Family Planning Perspectives*, vol. 4, No. 3, July 1972, pp. 33-36.

these media rather than actual definitions. In this case, a general definition was given, and the types of information media were listed. For some frequently used terms, the standardized definitions were worded in sentence form; for others, the common elements were outlined as seen in annex IV.

A. Service context

(a) Categories of contraceptive methods

55. The classifications of contraceptive methods in the study countries showed the least variation with regard to methods considered to be mechanical, chemical, surgical or hormonal. For reporting purposes, however, the more efficient contraceptive methods were almost universally classified under IUD, oral pills, sterilization (male and female) and injectibles. The less efficient methods were sometimes grouped together "conventional contraceptives." However, among these, the condom was often treated either as a separate category or along with chemical contraceptives. Methods such as withdrawal, rhythm and prolonged lactation were classified as natural, simple or traditional methods in different countries.

56. In order to make comparisons of the acceptance of conventional contraceptives from programme sources, it would be necessary to know which contraceptives were included in this category. This information could be particularly important to programme directors who looked to other programmes' experiences for planning their own resource inputs into similar promotional activities for specific contraceptives.

(b) Incentives, disincentives and compensation

57. Eight out of the 11 countries, i.e., India, Indonesia, Malaysia, Nepal, the Philippines, the Republic of Korea, Singapore and Sri Lanka used one form or another of these means designed to encourage family planning and discourage high fertility. Incentives were the most frequently implemented, of which there were generally two types in use: those for the "use-diffuser" and those for the "adopter". The former was directed towards those recruiting accepters, and the latter was awarded to those adopting family planning. Use-diffuser incentives were most commonly found in Indonesia, Nepal, the Philippines, and the Republic of Korea, while adopter incentives were given in Singapore and Sri Lanka.

58. Disincentives were implemented in Singapore, where *accouchement* fees progressively increased after each pregnancy, and in Malaysia, where maternity benefits stopped after the third pregnancy. Compensation was defined as payments to "those suffering a loss in wages or out-of-pocket expenses in order to receive or disseminate family planning services". Malaysia (in some states) and India compensated vasectomy clients. India, Indonesia and the Republic of Korea provided remuneration to staff employed to do family planning work outside of their routine duties. This remuneration was also generally termed "compensation" by the three countries.

(c) Information/education/communication

59. As mentioned earlier, standardizing these aspects of communication programmes was of little use, since most countries reported only the types of media that were used. This could be optimistically interpreted as evidence that a high degree of consensus existed on the nature of these terms. However, there might be an implicit problem of non-systematized use of these media listed in the annex IV. The types of IEC media were listed randomly, indicating perhaps that the communication programmes did not necessarily organize their presentations of these materials according to a master plan. If this was the case, it might be attributed to a lack of knowledge regarding the impact of certain media forms as well as the setting in which they would produce the maximum effects.

(d) Clinics, health centres, subcentres and others

60. These outlets for family planning services covered a range of institutions from depot holders, as in India, to large district hospitals with clinics attached. The definitions of these terms comprised important information necessary for understanding the scope of each national programme's activities. Above all, setting of the services characterized the degree of integration of family planning services with those of health in terms of staff inputs and buildings, depending upon whether the health and family planning programmes shared physical structure and facilities. The classifications of family planning centres varied. It was also apparent that the locations of the service facilities made a difference, since rural health centres differed from urban ones in type and composition, and their hours of servicing varied according to their full-time or part-time designations.

61. The staffing pattern was another factor that often determined the type of health facility. For most countries, a health centre was one staffed by a medical officer, whereas a subcentre was supervised by a nurse or paramedical person. Doctors from the health centre

might visit a subcentre regularly on certain days, as in Fiji, Hong Kong, Malaysia, Nepal and Singapore. This arrangement was known as a "satellite" clinic in Malaysia and as a "mobile team with fixed clinic location" in Hong Kong and Singapore.

62. An extended version of the visiting teams was found in India, Indonesia and Nepal. It involved a vehicle carrying a full medical staff to outlying areas to provide family planning services. It travelled on a need basis with or without any regular route and time schedule. However, for the fixed health facilities, the nature of the family planning services offered depended upon the presence of medical staff and the training of the paramedical staff.

63. The definition of a family planning clinic then primarily involved the service provided by certain staff. If one attempted to delineate the structural dimensions of a clinic, the definition became more problematic. A clinic might refer to the session devoted to family planning services on either separate days or portions of certain days. In this case, it would be held in a health centre or subcentre (with a visiting medical officer), or the clinic might itself be an independent edifice housed on the compound of a health institution. It might also be isolated in an area not covered by a health centre. Given the varieties of structures, it appeared that, next to the actual delivery of family planning services, the clinic's physical location was a second consideration for a standardized definition.

B. Family planning workers

(a) Multipurpose and unipurpose workers

64. Regular programme workers were broadly categorized into two types: (i) multipurpose workers who worked regularly for both health and family planning services; and (ii) unipurpose workers who devoted their full time to family planning motivation and services. The prevalence of one or the other type of worker again depended upon the degree of service integration with the health programme and the medical or paramedical nature of the worker's position. Doctors and nurses were often multipurpose, and family planning field-workers and clerical workers who recorded family planning service statistics at clinics were usually unipurpose. The latter group's recruitment generally occurred during the later stages of programme development, with their salaries financed from the family planning programme budget.

(b) Doctors

65. With regard to staff categories, five countries (Fiji, India, Malaysia, Singapore and Thailand) used the term medical officer for doctors. (With the exception of Thailand, this may reflect a colonial carry-over of the British medical notation system). The definition of a doctor or medical officer raised little problem, since almost all programmes required that their physicians have a recognized degree and be a registered medical practitioner. The definitions differed with respect to the physicians' programme functions, which was often governed by their availability. For most programmes, the ratio of qualified doctors to total population was too small; and this directly, if not severely, affected the delivery of the services. Integration with existing health facilities and staff had been advantageous in this regard, although at times the doctors were themselves in need of family planning orientation and training [2].

(c) Nurses

66. The nursing staff categories and the definitions of their duties varied according to programme needs and organization, and the amount of training. Four countries (Fiji, India, Nepal and Sri Lanka) had a staff position of public health nurse for family planning work. Background educational and training requirements were specific for the registered nurse in each programme. In some countries (e.g., Hong Kong and India) there was a secondary nurse position that required less training and involved duties supervised by the registered nurse. The functions of a nurse varied directly with the availability of and demands upon a doctor. In most proprammes, nurses could distribute oral pills and conventional contraceptives directly to clients and sometimes insert IUDs, although doctors were still required to perform the medical examinations and sterilizations.

(d) Midwives

67. Trained midwives were present in 8 of the 11 study countries (all except Fiji, Indonesia and the Republic of Korea), but the extent of their use for family planning purposes was not fully determined.

2/ Because full-time work in government service was not very lucrative, public doctors maintained part-time private practices whenever it was permitted. The narrow specialization of a family planning practice made the work even less attractive and thus programmes had difficulty in recruiting doctors to serve, especially in the rural areas.

Use of the trained midwife for family planning field duties was known to exist in India, Malaysia and Singapore, and the use of the traditional *bidan*, *dukun* or *moh tam yae* as motivators was experimented with in Malaysia, Indonesia and Thailand. (Traditional midwives in Indonesia are now used as motivators following successful experimentation.) A distinction was made between trained and untrained (traditional or village level) midwives, such as the auxiliary nurse midwives and the "dais" in India, since generally it was the trained midwife who was involved in family planning.

(e) Health inspectors and health educators

68. Health inspectors were generally not involved in family planning activities, although these positions existed in six countries. The health educator, however, was used for the dissemination of family planning information in three countries, namely, Malaysia, Singapore and Thailand. In India, the extension educator, who was not necessarily the health educator, was responsible for the family planning education programme in the primary health centre.

(f) Field-workers and motivators

69. Field-work duties were performed by a family planning field-worker; but, where such a position existed, the names and titles varied considerably. This position was generally filled by a non-medical individual who worked extraclinically, and was responsible for the motivational activities and accepter recruitment. Variations occurred, for example, in Sri Lanka, where public health midwives performed the field-work duties, but were part of the medical MCH staff. In the Philippine and Indonesian programmes, motivators were used for field-work purposes. In Malaysia, home visitation was not an officially encouraged policy; thus, outreach and follow-up efforts in the field were limited. There, motivation through IEC services became the responsibility of family planning field assistants and assistant information officers. In most other programmes that relied heavily on field-worker inputs, the duties of the worker often included the distribution of contraceptives to encourage the acceptance or continuation of family planning practice (India, Republic of Korea and Nepal).

C. Acceptance concepts

(a) Eligibility and eligible couples

70. Prospective adopters of family planning were generally screened for medical contra-indications to determine their eligibility for contraceptive use. While many programmes implied that their clients should be married and non-pregnant, these conditions were not explicitly stated in the definitions. Eight countries defined eligibility for contraceptive use on the basis of medical fitness with a "cafeteria" or "menu" approach towards selecting a contraceptive method officially offered in the respective programmes. Marital status was specified for Indonesian and Malaysian family planning clients. Eligibility for sterilization had more limitations by age and/or parity levels in Fiji, Hong Kong, India and Thailand.

71. The concept of eligible couples or target couples was defined entirely in terms of marital status and age. More often it was the wife's age that was specified rather than the husband's with varying age ranges. The 15-44 year age span was used for Fijian, Indian, Filipino, Singaporean and Thai women; 15-49 years were the limits for women in Indonesia, Malaysia and Sri Lanka. The Republic of Korea used a 20-44 year range for women. Thailand set an upper age limit of 59 year for men. The remaining programmes, in Hong Kong, Nepal and Singapore, stated that their services were open to all married couples exposed to the risk of unplanned pregnancy.

(b) Accepters

72. It appeared that, as a programme matured, its operational definitions of an accepter became more refined, and differentiations were made between the various types of accepters, e.g., new accepters, users transferees and discontinuers. The term accepter was defined in the Expert Group report on the assessment of acceptance and effectiveness of family planning methods as "the taking of service and/or advice from such a programme, i.e., having an IUD insertion or a sterilization operation or receiving supplies (or advice on methods such as 'rhythm' or 'coitus interruptus') with the intent of using the method"[3] All countries' definitions were in basic agreement, with some being more specific. For example, Malaysia allowed a woman to be classified as an accepter only once in her lifetime; Singapore required that an accepter be registered with the Family Planning Board and be using a programme method; and India recognized only accepters of IUDs, conventional contraceptives and sterilizations for their service statistics purposes.

73. Acceptance over time was differentiated by the terms old accepters (Hong Kong, Indonesia, Nepal, Sri

3/ United Nations, *Assessment of Acceptance and Effectiveness of Family Planning Methods, op. cit., p. 8.*

Lanka and Thailand) and users (Hong Kong, Republic of Korea and Sri Lanka) or continuing users (Malaysia and Nepal). These persons needed to be separated from those who had accepted for the first time during a clinic visit, i.e., the new accepters. The term new accepter was used in Fiji, Hong Kong, Indonesia, Nepal, Sri Lanka and Thailand.

74. Defining a new accepter was as problematic as defining an accepter. Classification began at the clinic; however, an individual who attended another clinic, used a non-programme method, was switching methods, or was a post-partum new accepter, regardless of her previous family planning practices, was likely to be classified as a new accepter unless an apparatus was available to discriminate her from the first-time accepters. Malaysia's programme made a considerable effort to classify clients as accurately as possible according to their visit status. Clients transferring from one clinic to another were sorted out to avoid reclassification, while provisional accepters [4] were recorded as such to avoid overclassification. In this manner, all new accepters reported were *bona fide*, and the enumeration was not infused with previous clients or very temporary ones.

(c) Dropouts or discontinued users

75. Irregularity of use was recorded or noted in terms such as irregular user (Hong Kong), discontinued user (Hong Kong, Sri Lanka), defaulter (Malaysia and Singapore) missed appointment (Malaysia), or dropouts (Philippines). All countries except Fiji, Indonesia and Malaysia reported that they distinguished between regular and irregular users of contraceptives. However, definitions needed to be more specific as to the point in time at which an accepter became a discontinuer. In certain programmes (e.g., those of Hong Kong, Malaysia, Nepal and Singapore), the service statistics systems reclassified accepters as discontinuers following their failure to return to the clinic for supplies after a certain grace period, or their refusal of a reinsertion of an expelled or removed IUD.

76. As contraceptive services became increasingly available, both from programme and non-programme sources, it was important that acceptance statuses be more definitive. For the evaluation of programme impact, it would be more accurate to identify all degrees of acceptance rather than to rely upon a gross enumeration of accepters. As the programmes matured, however, it was apparent that the concept of accepter became less important and that of user rose in priority. The perception of the need for an accurate picture of contraceptive use was one benefit that resulted from this recent concern over use-effectiveness of birth control practice. A differentiation of acceptance statuses, following an accepter, user, discontinuer pattern would aid inter-country comparisons. It was fortunate, in relation to the service statistics systems that, where specific definitions of accepters existed, the system had likewise been specific in its recording and reporting.

77. Further attempts at standardizing definitions of terms and concepts should focus on acceptance statuses as well as staffing categories. Efforts with respect to the first area should attempt to be as mutually exclusive as possible. Standardizing staff categories might not be particularly beneficial for comparative evaluation, but would definitely assist service efforts by trying to better co-ordinate programme needs and worker duties.

78. To conclude, there were wide variations in the definitions of terms for the country programmes in the region. First, the context of a programme largely influenced the usage and meanings of the terms relating to service. Second, family planning staff categories and consequently their definitions were affected by the administrative hierarchy, the degree of integration with the health programme and the availability of financial resources. Their incumbent duties were likewise affected by these dimensions of the programme and the intensification of programme inputs. The third area discussed in this chapter showed that the outputs of these programmes, i.e., their accepters, were in varying states of contraceptive use at any one time. Furthermore, the need to define these variations as accurately as possible was eminent. As they existed at the time of the study, the definitions of terms relating to acceptance, use and discontinuation were relatively lax in depicting the actual use of family planning. This situation of programme language made attempts at standardization of definitions less comprehensive than desirable, since the definitions were inextricably wound up with each programme's structure. The attempts here would, it was hoped, help programme administrators to become more aware of the normative interpretations that prevailed in similar programmes.

4/ A provisional accepter in Malaysia was a patient recruited from a maternity ward or through a home visit, who willingly took a first supply of contraceptives (oral, condoms, etc.). She or he was also given a clear explanation on how to use the method and was motivated to return to the clinic to be registered as an accepter and to obtain a resupply of contraceptives.

IV. COMPONENTS OF A SERVICE STATISTICS SYSTEM: RECORDS AND REPORTS

79. The basic elements of a service statistics system in any community action programme were the records of activities generated during the course of implementing the programme and the reports on these activities sent to higher levels of the administration which monitored the progress. Most of the family planning records were located at the clinic and were maintained by personnel whose primary responsibility was providing services to members of the community. In this respect, record-keeping was an additional function for the clinic staff and it was important that evaluators and administrators be cognizant of the possible burden that their data needs might entail.

80. Similarly, the full utilization for evaluation purposes of the information contained in the records and reports could not be guaranteed. The opinion had been expressed in the past that many of the records contained too many items of information, some of which were not necessary. Certain records partially overlapped, and information on items of programme inputs was not adequately recorded in a format that would facilitate reporting. Streamlining the number of records and reports was necessary and feasible.

81. It was hoped that through a detailed analysis of the contents and uses of the records and reports, the needed improvements in the service statistics network would become evident. This chapter confines itself to the various records and reports existing in the family planning programmes of the ESCAP region.

A. Categories of family planning records

82. The various family planning records can be grouped according to the following categories:

(a) Records relating to the potential or actual accepter at the
  (i) Population level
  (ii) Pre-acceptance level
  (iii) Acceptance level
  (iv) Follow-up level
(b) Records of services rendered at the clinic or outside, and of motivational activities by clinic staff
(c) Clinic facilities, staff deployment, transport, etc.
(d) Indent and supply of contraceptives, record forms and other consumable items
(e) Education, information and communication activities other than those by clinic staff
(f) Training
(g) Staff recruitment and turnover
(h) Budget and expenditure

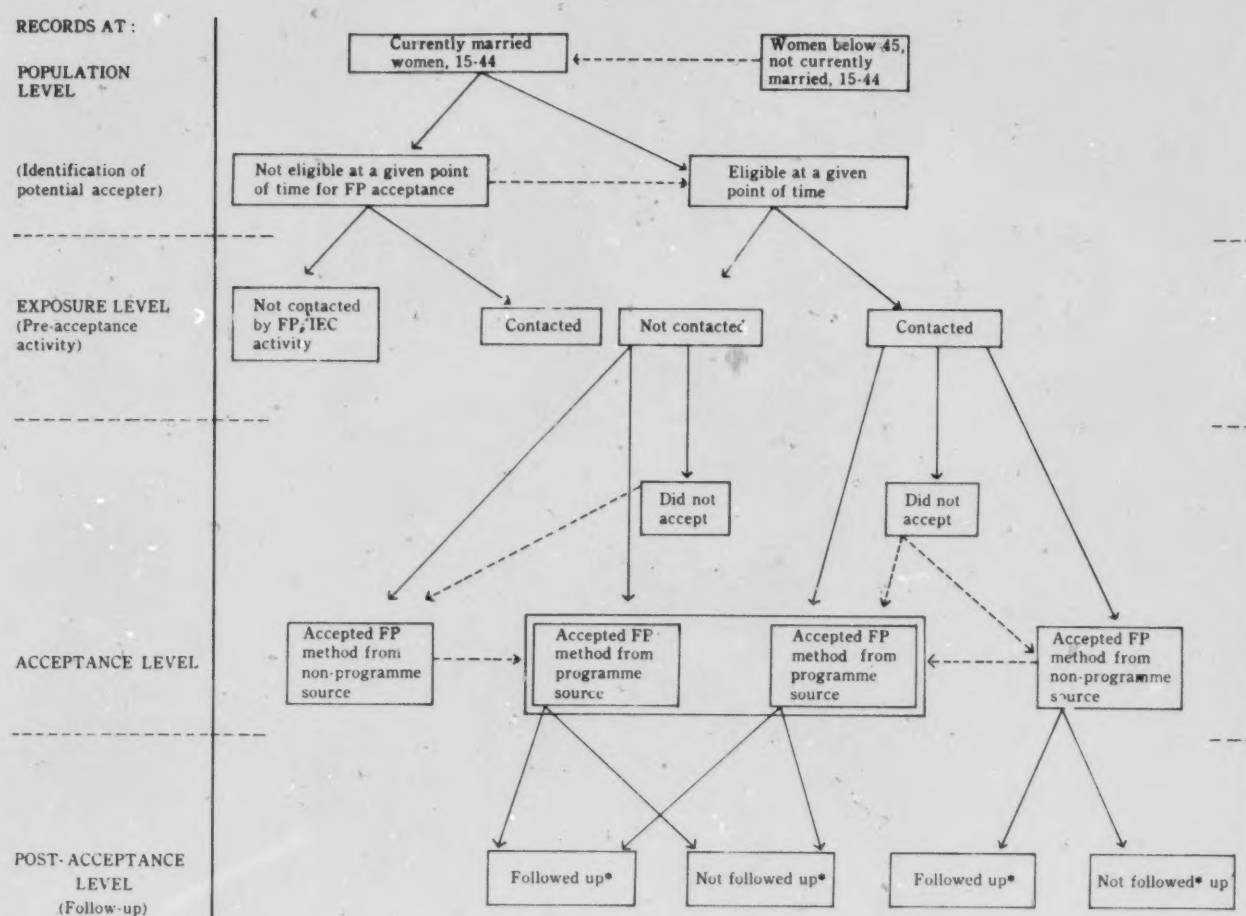
Records under (a), (b) and (c) were maintained exclusively at the peripheral level of programme implementation -- the service point -- while records relating to (d) existed at all supply and demand points. The remaining records were found only a higher administrative levels. (See annex V for a detailed description of their contents.)

83. The types of records could be differentiated by the stage of acceptance at which the record was introduced (see figure 1). For the first stage of acceptance, several countries identified their eligible populations commonly through surveys. In Fiji, an enumeration of all women 15-44 years of age, regardless of their marital or family planning status, was done in late 1969 by completing a family record card for each female. This card was continually updated by public health nurses during periodic home visits and by means of information on deliveries received from hospitals. Cards were added for new entrants into the eligible group. India conducted family planning surveys on which its target couple registers were based. (These were especially useful for dispensing sterilization introductory slips during mass vasectomy campaigns.) Similarly, Nepal's programme focused on recruiting those couples identified through a priority couple survey which rated their needs according to the wife's age and the number of living children. Other programmes such as Indonesia's used a registration mechanism to identify the eligible population either on a continuing basis or at one point in time. The quality of these registers and the extent to which they were kept up to date varied over the programmes as well as within each.

84. The second stage involved recording pre-acceptance activity, i.e., contacts with potential accepters. A variety of forms were used in Malaysia, Indonesia, the Philippines, Sri Lanka, Singapore and Thailand In India, the mass vasectomy camps used introductory slips, but this was the only setting in which a pre-acceptance form was used. For the other countries mentioned, forms were given to women who were contacted by field personnel in a motivational setting (e.g., post-partum contact in Singapore and Malaysia as well as the

Figure 1.

STAGES OF ACCEPTANCE AND RELATED RECORDS


RECORDS AT :
POPULATION LEVEL
(Identification of potential accepter)
EXPOSURE LEVEL (Pre-acceptance activity)
ACCEPTANCE LEVEL
POST-ACCEPTANCE LEVEL (Follow-up)
Currently married women, 15-44
Women below 45, not currently married, 15-44
Not eligible at a given point of time for FP acceptance
Eligible at a given point of time
Not contacted by FP/IEC activity
Contacted
Not contacted
Contacted
Did not accept
Did not accept
Accepted FP method from non-programme source
Accepted FP method from programme source
Accepted FP method from programme source
Accepted FP method from non-programme source
Followed up*
Not followed up*
Followed up*
Not followed* up

*Until termination of eligibility or until no longer necessary to follow up.

TYPE OF RECORDS

Family record card (F)
Target couple register family planning register* (Ind)
Priority couple survey register (N)
Mapping register (Ins)
Eligible women by state, district and their target (M)

Provisional accepter's form (M)
Referral/appt. form (Ins, P, S, SL, M, T)
Introductory slip for mass vasectomy camps (on *ad hoc* basis in India)
Coupon (K)

Client record card (all countries use one single card except India, where IUD and sterilization clients have separate cards and the Republic of Korea where the coupon is used)
Registers (all except the Republic of Korea)
Clinic index card (HK, Ins, S, T)
Patient ID form (Ins, M, P, T)
Sterilization form (F, M, N, S)
Accepter log book (T)
Appointment form (M, N, S)
Referral form (HK, M)

Follow-up form (HK, P, SL)
Return visit record (P)
Transfer form (M)
Client record card or method card reverse side (all countries except the Republic of Korea)
Reminder (S)

*Used also at exposure and post-acceptance levels.

F = Fiji
HK = Hong Kong
Ind = India
Ins = Indonesia
K = Republic of Korea
M = Malaysia
N = Nepal
P = Philippines
S = Singapore
SL = Sri Lanka
T = Thailand

Note: *Dotted Lines represent likely future movement from one group into another*

group meeting in Malaysia) and who expressed an interest in attending a clinic. In Malaysia, women who were given one cycle of pills for trial were classified as "provisional accepters" at the clinic, as noted earlier. The pre-acceptance record itself provided some psychological reinforcement for the potential accepter who had committed herself to a clinic visit.

85. Pre-acceptance records also demonstrated the utility of extension education services in deploying field-workers. The records could gauge the workers' performances in yielding gross measures of output, i.e., the number of contacted women who became accepters. However, the actual effectiveness of these forms in this sense had not yet been systematically evaluated by most programmes. This was primarily due to the restricted movements of the records beyond the clinic and its field staff.

86. Acceptance at the service point, the third level in the diagram, evoked a deluge of records, many of which were essential for smooth clinic operations. The most basic of these were the client record card and the clinic activity register (s), which formed the bulk of the base for reporting to higher levels.

87. The client record card included a face sheet in all countries except Fiji, India, Singapore and Sri Lanka for the purposes of reporting client characteristics. (In the Republic of Korea, a coupon system was in operation, and part A of the coupon served this purpose.) Fiji's recording system collected a few client characteristics, but only reported the racial background of accepters to higher administrative levels. Another exception was India, where IUD and sterilization clients had separate case cards, and the reporting of client characteristics had only been implemented recently on a quarterly basis. Singapore relied upon a microfilming team to synthesize client data and photograph the record form. In Sri Lanka, where two separate client record forms (one for the clinic and the other for field purposes) were used, a few client characteristics along with identification particulars of the client were copied onto the monthly return form and reported to higher levels.

88. The tabulation of accepter characteristics was facilitated by the use of these face sheets or other precoded reporting forms. These forms were usually forwarded directly to the evaluation unit, where they were sometimes sampled before processing. When mechanical or computer facilities were available, the tabulation was quicker, and more detailed analyses could be done. Service statistics systems not using this face sheet or other forms of direct transmission of accepter characteristics data, as in the Republic of Korea and Singapore, limited the amount of detail they requested on each accepter as well as the number of cross-tabulations that were ultimately derived.

89. The client record card was one form to which considerable attention had been devoted by research institutions with a view to developing an "ideal" design. National evaluation units had also made several changes over time in their client record forms to evolve a format best suited to their own programme purposes. A brief description of the types currently in use was judged to be worth-while and has been included at the end of this section.

90. For work within the clinic itself, the staff might use separate procedures for client registration and card retrieval. In this case, a clinic index card, a client identification card and a daily clinic activity register were often prepared. The clinic activity register, which went by different names in different countries, was universally used. A variety of other registers were also kept, especially in India and Nepal. The registers collected the data regarding the date and type of service rendered, further services needed by the client, some background information on the client and sometimes motivational activities. They served to ensure the proper processing of the client and delivery of family planning services.

91. Lastly, postacceptance information became useful knowledge for the evaluation of programme performance. Follow-up information either through return visits to clinics or through extension services was useful for obtaining data for calculating continuation rates at the central level as well as for assisting the clinics in their responsibilities to support as many contraceptive users as possible. Follow-up information was recorded in a separate section on the client record card in all countries. Forms specifically for post-acceptance activity were used in Hong Kong, the Philippines and Sri Lanka. The "return visit record" in the Philippines monitored the continued contraceptive practice of a 10 per cent sample of accepters.

92. Records for programme activities and management, listed under (c), (e), (f), (g) and (h) outlined earlier, are treated compositely here. It is felt that their fundamental value for this comparative analysis of service statistics systems lies in the fact that they contribute to facilitating programme management. The

forms represented a valuable source of input data, which provided information on the consumption of physical and financial resources by the different programme facilities. It was possible to generate performance indices wherever data on staff inputs, in terms of man-hours spent in the clinic or in outside motivational work, were recorded routinely. The inclusion of clinic staff, training and IEC inputs on the records also provided further bases for performance evaluation; salary disbursements to clinic staff and financial data on separate programme operations could be converted into cost analyses. With the appropriate output data, e.g., the number of accepters, couple-years protected, births averted or any other suitable measure, ratios of output over outlay could be calculated. These could serve to monitor the efficiency and effectiveness of the programme over time.

93. Most countries generated at least one measure for evaluating performance, usually in terms of achievement. However, they were not necessarily output-input ratios, and much stood to be gained through a more extensive application of this evaluation method. The development of suitable indices, which would accurately indicate the success or lack of it in a programme, was necessary. These measures would show whether a programme was increasing the extent of contraceptive use and simultaneously deriving maximum use from its resources at hand.

94. The records relating to the administrative aspects of the programme were not as comprehensively reported as those dealing with the acceptance process. It is recognized that, as a potential area for improvement, the former records could be modified to streamline the contents with a view to collecting the data in a form useful for output-input analysis. Given this premise, it is not as profitable to compare these administrative records of the various countries here in terms of their present format or variables.

B. Indent and supply system

95. Special attention was paid in this report to the indent and supply systems. This was justifiable in light of the current cost-consciousness regarding the use of programme resources, particularly where international inputs were concerned. Mobilizing the supplies quickly and efficiently meant a more continuous and unhampered operation. In this respect, it was as important to ensure the availability of contraceptives at the service points as to maintain all other levels of programme activity. The allocation of vehicles, clinic equipment, record and report forms, etc., also needed to be recorded and supervised through a system of checks and balances.

96. Every country had a supply form which, in some cases, was a return form, an indent form or both. The supply system varied considerably depending on the location of the authorizing body for requisitions. (Annex VI outlines the procedures of these systems.) If the supply requests originated at the clinic and were approved by an intermediate supervisor (usually a medical officer), the central level's responsibility was then to ensure that local warehouses were adequately stocked. The supervisor was also responsible for checking that the supplies were used legitimately and for maintaining over-all accuracy in the reporting. This type of indent-supply system existed in all study countries except Indonesia, and the Philippines, and to some extent the Republic of Korea.

97. The Indonesian and Philippine programmes operated on a non-request basis, which meant that their logistics units determined the supply amounts, particularly for contraceptives, needed at each service level. The supply forms involved here contained information on receipts, distributions and balances which gave the unit an idea of the flows and demands upon centrally stocked as well as area warehouse supplies. By maintaining this surveillance over programme changes, the logistics unit could fix the supply amounts and distribute them relieving the clinic staff of indent duties. Because of its management of the equipment, supplies and personnel salaries, the logistics unit also became a major source of input information.

98. In the Republic of Korea, the annually targeted accepters were fixed and method-specific. Therefore, the contraceptive supplies were also pre-determined by the central administration. These were then allocated to the local health centres usually at the beginning of the year. The regulated nature of the supplies meant that the Korean programme was not as upwardly flexible, although the targets were ambitious enough to accommodate small surges in acceptance.

99. The supply systems of the other study countries relied upon the service units ledgers of supplies consumed. The intervals at which this information was transmitted varied according to the forms in use. In some places, e.g., Hong Kong, India, Malaysia, Singapore, Sri Lanka and Thailand, two forms – a stock return and a requisition form—were used. The stock return informed the administration of the consumption of supplies and the requisition form listed supply needs. These could be submitted together each month or quarter or separately at varying intervals. Often, the return was sent to the central level regularly, while the requisition form was submitted as supplies were needed

100. If the administrative emphasis lay with the clinic, its supply forms were prepared in multi-copies and sent directly to the central offices. If a clinic's supply needs were to be consolidated with those of others, then an intermediate level submitted one form to the central disbursing unit or executed the request through the area warehouse. The clinics of smaller programmes, such as in Fiji, Hong Kong and Singapore, could operate in direct contact with the central supply unit and eliminate the need for middle-level co-ordination.

101. Regular reporting by non-programme distributors of contraceptives was solicited in several countries. The degree to which this was successful is outlined in annex VII. Maintaining surveillance over private practitioners was most difficult, particularly where abortions were concerned. Commercial suppliers also tended to be erratic in reporting their estimates of distribution or sales of conventional contraceptives and oral pills. Where it was attempted, the responsibility for assembling this information periodically usually lay with the logistics unit or with the evaluation unit of the programme.

102. In summary, all programmes recorded their flow of supplies, particularly contraceptives, through regular clinic reporting. Requisitions were often handled on separate forms requiring the approval of a supervisor, except for those countries using a non-request system. Each country used different methods to verify stock receipts and distribution balances as well as to oversee their proper allocation. As a parenthetical note, the data on the distribution of contraceptives sometimes became a gauge for verifying the number of accepters reported and was used by a few programmes for this purpose.

C. The client record card

103. Returning to the client record card, three broad types were identified: (a) a "client-specific" record, which was a single record for each new accepter irrespective of the first method accepted and which potentially identified each client uniquely; (b) a "method-specific" record which was separate for each method accepter; and (c) the coupon. Client-specific records were used in all countries except India, which used the method-specific records, and the Republic of Korea, which used the coupon. The main virtue of the client-specific record lay in its ability to maintain prospective data on all subsequent methods used by the client, theoretically until the end of her eligibility status. Properly maintained and with careful follow-up, such a record would yield estimates of use-effectiveness as well as extended use-effectiveness and would weed out the double counting of accepters due to a method switch, which was not possible with the method-specific records. Typically, the client-specific records were in use in programmes which generally emphasized female methods of contraception: the pill, IUD and tubal ligation. In Nepal and Singapore, a combination of method-specific and client-specific records was in use, in the sense that there were two records. In Nepal, one record existed for pill and IUD clients and another for vasectomies. Singapore used method card insets for the pill, IUD, sterilization and "miscellaneous contraceptives" in its client folder. Both Fiji and Singapore used a separate record form for sterilization clients.

104. The client record form usually contained information on (a) accepter characteristics (socio-economic, demographic, contraception-related, such as method currently accepted, past contraception, source of motivation and reason for acceptance); (b) medical history (obstetric, menstrual and others); (c) medical examination findings (general, pelvic and method contra-indication-related); and (d) subsequent observations and services (either at the clinic or through home visits). (See annex VIII.) The demographic characteristics of the accepters appeared to be well standardized in the client records of the programmes under study with information on age of accepters and number of living children available in all records. Other items on which information was commonly solicited included the number of living children by sex (all except Sri Lanka), open birth interval (all except the Republic of Korea) and the number of live births (all except Sri Lanka and Thailand). The purpose of using contraception (spacing versus limitation) was sought in all programmes except those of Fiji, India and the Republic of Korea. The programmes in Sri Lanka, Hong Kong, Malaysia and Singapore recorded information on the duration of marriage.

105. Relatively less uniformity was observed in the recording of information on socio-economic status. Education was recorded in all programmes except those in Fiji and Sri Lanka; race and/or religion was included in all client records except in Nepal, the Republic of Korea, Thailand and the Philippines. The occupation of the husband could be found in the client records of six countries: Hong Kong, Indonesia, Malaysia, Nepal, Singapore and Thailand. Only Hong Kong, Malaysia and Singapore collected information on income. The rural-urban nature of the client's residence could be determined from the client records of most countries.

106. With regard to contraceptive practice-related information, all countries except the Republic of Korea and Sri Lanka had information that distinguished between an ever-user and a never-user at the time of acceptance. In addition, Hong Kong, the Philippines and Singapore had information on the first method used; Fiji; Hong Kong and Singapore on the time interval since first and present use; and Malaysia and the Philippines on whether the client had been a "family planning clinic accepter" previously. Reasons for discontinuation were recorded in Malaysia and Singapore; this information was also generally available from the remarks of the doctor or paramedical worker in the follow-up records of all countries except perhaps the Republic of Korea. Information on the source of referral was solicited in eight countries: Hong Kong, India, Indonesia, Malaysia, Nepal, the Philippines, the Republic of Korea and Singapore.

107. The bulk of the information collected on the client record card was clearly of medical interest and for use at the clinic. The medical information recorded at the time of acceptance and during follow-up visits might help the doctor in treating the client on occasions of contraceptive-related complaints. Information relevant to programme evaluation was available from the recording and subsequent reporting of client characteristics for assessing the trends in accepter profiles. Information on sterilizations and abortions, where collected on a separate record, were usually processed separately as well. Information regarding discontinuation recorded in the follow-up section of the record could provide estimates of use-effectiveness as well as the reasons for discontinuation. These records could also serve as a sampling frame for follow-up surveys.

D. Reports

108. All records other than those kept exclusively for use at the service points generally contributed to information contained in the reports (annex IX). However, while these records were normally maintained at the service points, reports did not necessarily originate there. All programmes had a prescribed format for monthly reporting to the central evaluation unit, and the level at which the report was first prepared in this format was not always the lowest-level service point. For example, in India, while subcentres reported their activities to the primary health centre, the report on clinic activities to the central evaluation units was prepared at the primary health centre. Similar situations also existed in other programmes, e.g., those of Fiji, Nepal, the Republic of Korea, and Thailand. The following discussion is confined to such reports only, and their original source is referred to as the "primary reporting unit".

109. Two reporting systems could be identified. In one, the primary reporting unit sent the reports directly to the central evaluation unit, bypassing intermediate levels. This system existed in all programmes established after 1966, i.e., those of Indonesia, Malaysia, Nepal, the Philippines and Thailand. In Hong Kong and Singapore, no intermediate administrative organization existed. In some of these programmes, copies were also concurrently sent to the intermediate administrative levels. In the remaining countries, Fiji, India, the Republic of Korea and Sri Lanka, the reports emanating from the primary reporting unit were consolidated at each higher administrative level until they reached their top destination.

110. The most commonly reported items pertained to client characteristics and clinic activities, which were forwarded every month within a given time limit. Invariably, countries which sent reports directly to the central evaluation unit used a face sheet with the client record to report on accepter characteristics. The only exception was in Singapore, where staff from the evaluation unit visited clinics fortnightly and microfilmed the characteristics directly from the client records for further processing. The face sheets usually were copies of all the information on the client card relating to demographic and socio-economic characteristics and previous contraceptive use. The advantage of this device was that a large number of cross-tabulations of characteristics could be made at the central evaluation unit without burdening the clinic staff with extra work.

111. In Sri Lanka, information for each new accepter on age, number of living children, age of last child and method accepted was transferred to a "monthly record of family planning work" from the client record and sent to the central evaluation unit, sometimes through an intermediate-level office. In the Republic of Korea, part A of the coupon, which carried information on client characteristics, was sent directly to the evaluation unit. In India, where the systematic reporting of client characteristics began only recently, primary reporting units sent distributions of new accepters of each method by a few characteristics to be consolidated at district and state levels before being forwarded to the central evaluation unit.

112. The monthly reports usually were summaries of daily work extracted from the daily work registers and included the work done at the clinic as well as that

done by clinic staff in the field (except in Hong Kong and Singapore, where copies of daily clinic records were sent to the evaluation unit). The report invariably contained information on new accepters by method and often on revisits and total caseload. Reports on motivational activities, inventory and supplies, personnel, etc., were included in the same report in some of the countries.

113. Reports relating to training, information-education-communication, recruitment of staff, etc., originated at a higher level than the clinic. Mention might be made here of the "missed appointment report", the "follow-up missed appointment report" and the "active users report" in Malaysia and a return visit report for a 10 per cent sample of client records in the Philippines, which were attempts to estimate contraceptive continuation in a systematic manner without resorting to a follow-up study.

114. The flow chart of recording and reporting in figure 2 displays the elements of information incorporated in the information systems of the family planning programmes in the ESCAP region that were studied. The diagram should not be taken as a suggestion that separate records and reports should exist as shown in the flow chart. Evaluation personnel openly admitted that more information was reported than was ultimately utilized and that collection was habitually prolonged. (Monthly clinic reports were not included in this criticism since they were often the only channel for monitoring a service unit's progress.) It was agreed that condensation when possible would be a far more effective approach to adopt. Some programme activity reporting, e.g., IEC, training, motivational projects, could be reduced to quarterly compilation.

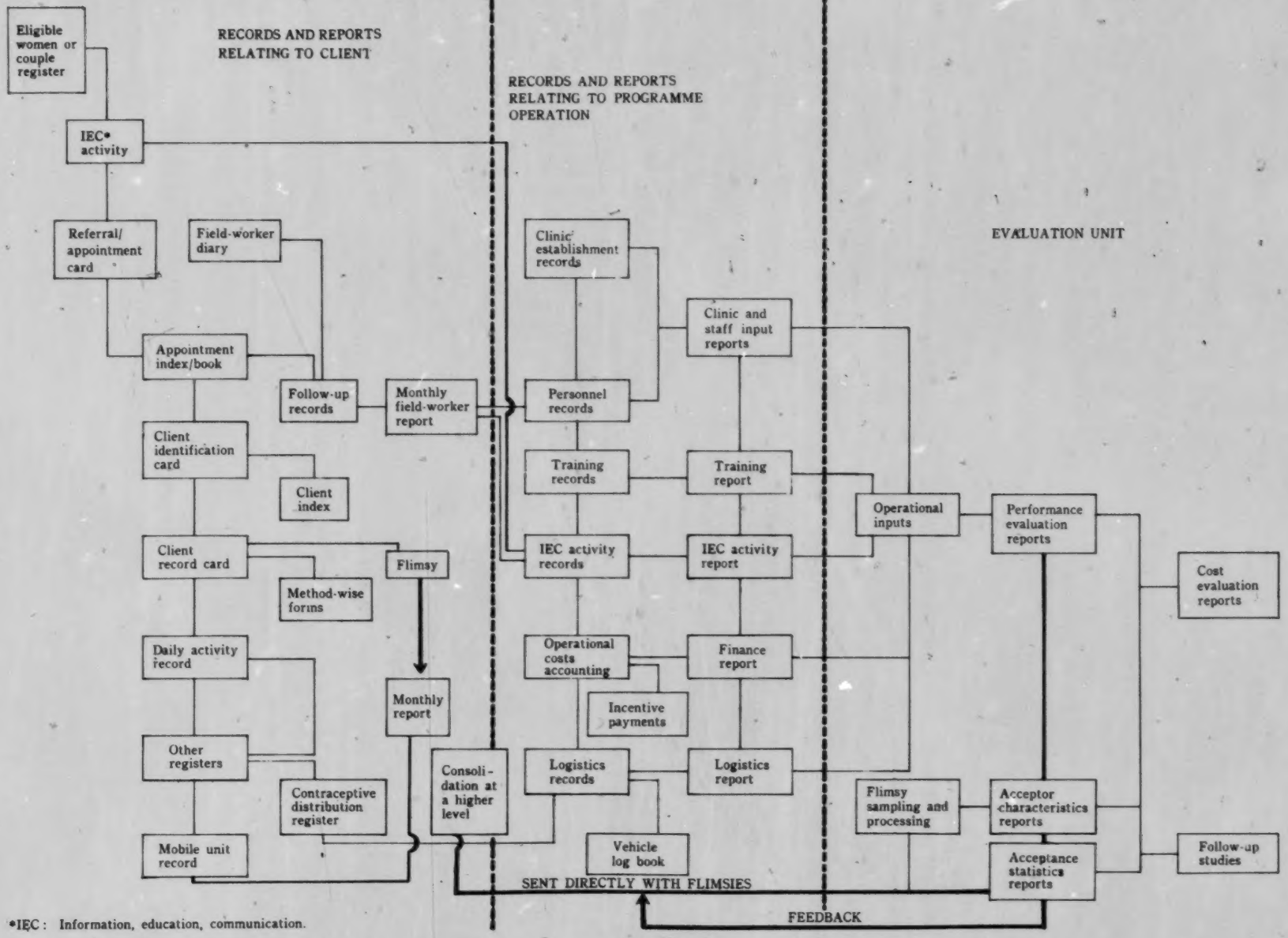
115. One problem chronically afflicting some programmes was that of achieving 100 per cent clinic reporting. An improvement in this direction was found in the Indonesian and Philippine information systems' experience where business-reply envelopes or postage-paid addressed envelopes were used for sending in reports. This innovation speeded up and increased the completeness in reporting. This method would be particularly advantageous for countries with widely dispersed clinics. Other mechanisms to encourage prompt reporting are discussed in chapter VI of this report.

116. By isolating and analysing records and reports out of their information system context, this discussion may have created some confusion. To gain a perspective on the number and purposes of these forms, tables 4 and 5 were prepared as a summary of the records and reports used to cover the client, the clinic and other programme activities. While the actual frequencies of forms existing in the study countries would not necessarily indicate a clerical burden for their service personnel, it was questionable how many were fundamental for operations and/or necessary for evaluation. The table revealed that India, Indonesia and the Philippines occupied the upper stratum of total forms in use for recording and reporting, with the Republic of Korea at the lower end. For records alone, India, the Philippines and Singapore dominated, with the Republic of Korea again using the fewest number. The number of different reporting forms used were highest in India and Indonesia, and the lowest in Fiji. Individual reporting forms appeared to be relatively more comprehensive with regard to coverage in Nepal and Hong Kong, as well as in Indonesia (for client-related activities).

117. The proliferation of forms is immediately obvious and the potential for combining records or eliminating some is seen as an eminent issue. The problem of data utility arises out of this issue as well. While a large portion of the recorded information was meant for clinic use only, not all of the remaining recorded information was reported. Furthermore, not all the reported information was analysed. Since the amount of clinic staff time diverted to preparing the forms means less time to spend on clients, it is important that the basic purpose of the service statistics systems not interfere with the programme's over-all purpose. For example, in one programme the field-workers reported that 25-35 per cent of the clinic staff's time was spent on recording. The service statistics system was developed primarily for evaluation purposes, and as a superimposed dimension to the programme, its needs should not hinder service efforts. Programme achievement depended upon the action originating at the clinic, and restricting this output with excessive reporting requirements could become counter-productive.

Figure 2.

A FLOW CHART OF RECORDING AND REPORTING



•IEC : Information, education, communication.

Table 4.

TYPES OF RECORDS IN USE IN STUDY COUNTRIES[a/]

RECORDS	Fiji	Hong Kong	India	Indonesia	Malaysia	Nepal	Philippines	Republic of Korea	Singapore	Sri Lanka	Thailand
Records relating to clients											
Client record card	x	x	x (IUD)	x	x	x	x	x (coupon)	x	x (2)	x
With flimsy/copy		x		x	x	x	x	x			x
Sterilization	x		x		x	x			x		
Referral/appointment				x	x (2)	x	x		x		x
Clinic index card				x					x		x (tickler)
Patient ID card				x	x		x				
Follow-up		x		x			x		x		
Others	Female population card				Transfer form; provisional accepters form		Return visit record		Abortion card; post-partum contact form		
Register											
Daily clinic record	x	x	x	x	x	x	x		x	x	x
Method-specific			x (4)			x (4)					
FP activities			x			x			x		
Others			x (4)				Client log-book		Appoint-ment book		Accepter log book
Clinic operations											
Personnel				x			x	x			
Supply forms	x	x (2)	x	x (2)	x (2)	x	x (3)	x	x (2)	x (2)	x (2)

Table 5.

TYPES OF REPORTS IN USE IN STUDY COUNTRIES

REPORTS	Fiji	Hong Kong	India	Indonesia	Malaysia	Nepal	Philippines	Republic of Korea	Singapore	Sri Lanka	Thailand
Regular-inward[b]											
Service unit (monthly)	x		x (4)	x	x (2)	x	x	x	x weekly	x (2)	x
Consolidation at an intermediate level	x		x					x		x	
Field-worker (monthly)		x		x		x					
Training activities			x (2)	x		x	x[d]				
IEC activities			x	x		x					
Supply/equipment			x (includes staff input)	x			x		x		
Finance							x				
Others				Programme achievement report	- Follow-up - Missed appointment						
Regular-outward[c]											
Monthly		x	x	x	x	x	x	x	x	x	x
Quarterly	x		x	x	x	x	x		x	x	
Semi-annual								x			x
Annual	x	x	x	x	x	x	x	x	x	x	x
Method-specific		x				x					x
Staff performance		x				x	x				
Accepters		x (3)		x (2)			x				
Others						Detailed FP report. Clinic Summary Report	Institution performance, Local govt. feedback				
Special follow-up, accepter characteristics, cost-effect studies, etc.		x	x	x	x	x	x	x	x	x	x

NOTES

(Tables 4 and 5)

(a) This table reviews all forms involved in an individual country's service statistics system. A cross mark indicates that there is an individual record or report in use primarily for that item. The absence of a cross mark does not mean that the information is not collected or available, since it might be included in other forms. The figures in brackets indicate the number of forms in use for the particular item if there are more than one forms.

(b) Flowing into the evaluation unit.

(c) These are regular reports produced at these intervals and their contents usually involve acceptance patterns. There are other special programme areas that also are regularly reported, such as those regarding method complaints and certain forms of feedback.

(d) Reported by the parent institution.

V. COMPONENTS OF A SERVICE STATISTICS SYSTEM: TABULATION, ANALYSIS AND FEEDBACK

A. Tabulation and analysis

118. The tabulation of service statistics reports concerned four broad areas: (a) characteristics of the recipients of services; (b) acceptance trends of services; (c) effectiveness of the programme in terms of measures such as protection provided to women, reduction of fertility levels, etc.; and (d) efficiency of programme implementation. The routine analysis of service statistics was generally confined to the first two of these in the countries of the ESCAP region. The third area also received attention in several countries, particularly during the past few years; however, by and large, the last area seemed to be the most neglected.

(a) Recipients of services

119. Knowledge regarding accepter background is valuable for programme administrators to identify the recipient groups. By comparing the background of accepters with that of the general population, it is possible to determine which groups were relatively less represented among the accepters so that more intensive programme efforts could be directed towards them. For example, Singapore programme officials were beginning an intensified effort to recruit more accepters from the "hard-core" female population, those of older ages, lower incomes and with larger family sizes. While the characteristics of the so-called hard-core might vary from one country to another, their identification was facilitated by the examination of trends in accepter attributes. This information, particularly on demographic characteristics, is also useful for estimating programme impact through the calculation of births averted. Additionally, data might be collected on the racial or religious background of accepters in some countries where they were matters of special interest.

120. The tabulation of accepter characteristics was a regular feature in all countries' progress reports with the exception of Fiji, which reported only the racial background of accepters. With that exception, all countries had an idea of the composition of their accepters in terms of age, parity, living children, education and rural-urban distribution. Most continued to analyse the incoming data on new accepters regularly. Hong Kong, India (recently implemented), Indonesia, Malaysia, Nepal, the Philippines and Thailand had individual quarterly or half-yearly reports devoted to the analysis of accepter characteristics. Some of these countries prepared 25 or more cross-tabulations on accepter characteristics.

121. Frequent tabulations of accepter characteristics appeared to be unnecessary. In the Republic of Korea, the profile of accepters had changed little during past several years. Thus, for some older programmes an annual analysis could be considered adequate. Younger programmes such as those of Thailand, Indonesia, and the Philippines found it necessary to maintain a closer observation on their accepters. Even so, a quarterly tabulation of accepter backgrounds was not likely to reveal significant changes. However, when major changes in programme operations did occur, particularly with regard to recruiting efforts or the introduction of new contraceptives, accepter characteristics were needed to indicate whether these changes altered the pattern of programme achievements by appealing to different sectors of the eligible population.

122. For several programmes, the analysis of accepter characteristics data could be reduced to a minimum number and mutable selection of variables. The continual cross-tabulation of demographic and social characteristics where variation was minimal was symptomatic of the "research syndrome" that demanded time-specific completeness and consistency. For programme operation purposes, focusing the tabulation and analysis on problem areas and less frequently checking the flourishing ones could be more beneficial.

(b) Acceptance of services

123. Tabulation and analysis of acceptance trends showed considerable variation in detail and amount of interpretation in the different countries studied. The 1969 ESCAP seminar report on programme evaluation recommended a core list of four tables with respect to acceptance analysis:

> "(i) Monthly number of new accepters, by method and administrative area.
>
> (ii) Cumulative number of new accepters, by method and by area during the fiscal year up to the time of reporting, to be prepared each month.
>
> (iii) Where appropriate, targets for the year, by method and by area, and the percentage of the proportionate target achieved up to the time of reporting.
>
> (iv) If information on population size was available, monthly tabulations of number of accepters per 1,000 population by method and area might also be made"[1].

1/ United Nations, *Evaluation of Family Planning Programmes* (United Nations publication, sales No. E. 70. II. F. 20), p.8.

124. The extent of variation among programmes relative to this scheme is apparent in table 6, which shows a cross-country comparison of acceptance tabulations. Tabulating the monthly number of new accepters by method and area would seem to be a common exercise, but it did not occur consistently. Some programmes reported only a method-specific breakdown, while others provided quarterly but not monthly figures with these breakdowns. Finding a commonality among countries on cumulative acceptance statistics was even more difficult, since area and method differentiations were not always present. Also, some programmes reported by a calendar rather than fiscal year.

125. Performance against method or area targets, where they were appropriate, gave measures of achievement within programmes as well as between them. The Republic of Korea and India had the only two programmes studied where these tabulations were made regularly. Indonesia, Malaysia and Thailand produced these data differentiated by area only. The data were also available in Malaysia, although only on a quarterly basis. Five countries (Fiji, Hong Kong, Nepal, Singapore and Thailand) which did not have targets had some other performance indices to evidence programme progress.

126. Six countries (Hong Kong, Malaysia, Nepal, the Republic of Korea, Singapore and Thailand) did not calculate any acceptance rates standardized for the total population, while the other five used varying denominators and numerators for their standardized rates. For example, the "percentage protected" figure was calculated in Fiji quarterly[2]. The Philippines, Indonesia, and India used the *cumulative* number of accepters and Indonesia and Sri Lanka used only *new accepters* for the numerators of their acceptance rates.

127. The prospects of standardizing even basic tables such as these would obviously present some problems. There was much variation among the types of tables that were prepared regularly. There was also a wide divergence from the tables recommended at the ESCAP seminar. However, one justification for not using a standardized set of tables was the priority of specific programme needs. Statistics were designed to service the information needs of all levels of personnel in order to facilitate their operations. If their needs as well as the present processes of planning and policy-making were dependent upon a prescribed tabulation format of acceptance variables, then these warranted more attention. Similarly, if motivating the clinics to increase their outputs depended upon a statistical breakdown with respect to the clinic rather than administrative area, as it did in Hong Kong, Malaysia, the Philippines and Singapore, standardization again would be a secondary concern.

128. However, unless both method and area targets were unavailable, preparation of the recommended tables was not a particularly demanding exercise. They contained fundamental information that any programme could generate routinely. Method-specific acceptance data were always available, and recent estimates of population by administrative areas were obtainable so that accepter/population ratios could be calculated. It was equally important that these tabulations be made continuously to provide a time dimension for monitoring purposes. If possible, weighting by accepter characteristics, e.g., age, parity or motivational inputs, could supplement current forms of analysis.

(c) Evaluation of programme effectiveness

129. More sophisticated cost analyses as well as calculations of births averted and couple-years of protection measures were available in India, Indonesia, Malaysia, the Philippines, Singapore and Thailand. These reflected the growing concern over the efficiency as well as the effectiveness of family planning programmes. Continuation rates of programme methods were necessary for calculating the protection factors. Estimates of these rates were attempted through service statistics channels in several countries by using the information on the "follow-up sheet" of client records. Programme evaluators in the national programmes agreed that these estimates were subject to biases and errors from several sources. Several programmes attempted to validate these estimates or determine the extent of error through follow-up surveys. Several surveys were based on nation-wide samples; service statistics records generally provided the sampling frames for these surveys [3].

130. The follow-up efforts of some programmes revealed disappointing results while the relatively high continuation rates of others were gratifying.

2/ Percentage protected = sum of monthly sales of pill cycles, condoms (divided by 10), cumulative total of IUDs *in situ* and cumulative total sterilizations, divided by the total number of women aged 15-44 years..

3/ Another source of continuation statistics were sample surveys wherein pregnancy and family planning practice histories were collected, usually in conjunction with a knowledge, attitudes and practice (KAP) survey as was done in the Republic of Korea. This practice, however, was not a *bona fide* element of the service statistics system, and evaluators generally had to rely upon follow-up data for a close monitoring of continuation.

Table 6.

TABULATION AND ANALYSIS OF ACCEPTANCE STATISTICS:

Degree to which ESCAP recommended core tables are available in study country reports

ESCAP Recommended Core Tables [a]	Fiji	Hong Kong	India	Indonesia	Malaysia	Nepal	Philippines	Republic of Korea	Singapore	Sri Lanka	Thailand
(i) Monthly number of new accepters by method and area [b]	Quarterly number of accepters by method. Quarterly number of protected by area	Yes	Yes, but not reported for each month	Yes	Yes	Yes	Yes, but not by area	Yes	Yes, but not by area	Yes, but method-wise acceptance available only quarterly	Yes
(ii) Cumulative number of new accepters by method and area during fiscal year up to the time of reporting, to be prepared monthly	No	Yes, but only by method (cumulative from Jan.)	Yes (year begins in Apr.)	Yes, but only by area (begins in Apr.)	Yes (begins in Jan.)	Yes, by area	Yes, but not by method (prepared quarterly begins in Jan.)	Yes, but not necessarily new accepters (begins in Jan.)	Yes, but not by area (begins in Jan.)	Yes, but only by area (begins in Jan.)	Yes, but cumulative since beginning of services (1972)
(iii) Where appropriate, targets for the year by method and area and the percentage of proportionate target achieved up to time of reporting	No accepter targets	No method or area-wise accepter targets	Yes	Yes, but only by area	Yes, but done quarterly and no method-wise targets	Yes, by area	Number of monthly accepters per clinic is the only target used	Yes	No method-wise or area-wise targets	Yes, but only by area	No

[a] This table was compiled from reported data. It is possible that these core tables are tabulated monthly but not included in the reports available to ESCAP.

[b] ESCAP recommended differentiating by administrative area. Here, any regional divisions were included since they may superimpose the programme administrative areas.

Table 6 (continued)

TABULATION AND ANALYSIS OF ACCEPTANCE STATISTICS:
Degree to which ESCAP recommended core tables are available in study country reports

ESCAP recommended core tables	Fiji	Hong Kong	India	Indonesia	Malaysia	Nepal	Philippines	Republic of Korea	Singapore	Sri Lanka	Thailand
(iv) Monthly tabulations of number of accepters per 1,000 population by method and area (when population data are available)	Proportion of total population that are accepters by method and area; proportion of eligible population "protected" by method only	No	Yes, but reporting is cumulative	Cumulative number of accepters, but only by area	No	No	Only the Number of cumulative FP accepters per 1,000 eligible women is prepared quarterly (not done by method; sent to local government officials)	No	No	Quarterly number of new accepters per 10,000 population by area only	No
Comments	Available annualy only. Percentage protected is available quarterly		India's monthly progress report is cumulatively calculated beginning the year in April				Rhythm is a programme method			Estimated 35 per cent of the clinics not reporting	

Problems relating to the oral pill evoked some concern among the officials of programmes which were originally enjoying high acceptance rates. Follow-up studies (as well as clinic reports) showed that a significant amount of consumer dissatisfaction was due to fluctuating brand supplies, which led to high discontinuation rates.

131. Mention might be made of Hong Kong, where the special problems occurring with IUD use were regularly analysed. Complaint statistics and data on complications reported to clinics by IUD adopters were compiled, as well as reasons for not returning to the clinic. Specialized analyses were also being done on field experimentation with new methods such as the Copper-T-IUD and hormonal injections.

132. Tabulations and analyses of programme statistics ultimately are made for some form of programme evaluation. The extent to which the evaluation of management and services occurs often reflects a certain amount of political emphasis on the programme as well as a concern over its improvement. Accepter recruitment then becomes not just a matter of boosting acceptance figures but entails a commitment that each accepter be properly serviced to prolong her or his practice. Naturally the latter involves additional efforts which contribute to over-all cost as compared to those programmes that only concentrate on acceptance. In this respect cost-effectiveness analyses done periodically in a few countries justified the investment of resources in these directions.

(d) Management of services

133. Certain reports on programme inputs flowed into the central evaluation unit with some regularity, allowing a sufficient overview for progromme maintenance. Beginning at the clinic level, data were collected regarding the clinic's establishment—its working hours, its sanctioned staffing and its initial supplies. Thereafter, data were sent regularly to the central level or implementing unit to report any changes—staff *in situ*, status of the equipment and supplies, etc. There was, however, no clear indication of how much systematic analysis of such data was done or how regularly and completely the data were collected. Indonesia and the Philippines kept the clinic management data on file. It was more than likely that all other countries also kept such data, although they did not report on this specifically.

134. Personnel data also required analysis since they provided information on resource input. Some programmes, such as those in Nepal and the Philippines collected data on staff inputs from the monthly clinic reports. The Republic of Korea used a central file system on family planning field-workers that noted their background, education, training and work experience. The data regarding personnel and clinic backgrounds could be made available to programme evaluators, although such information might not be centrally filed but rather dispersed in different administrative-level offices. Data on man-hour inputs by workers at all operational levels were less accessible.

135. Monitoring staff inputs at the clinic was complicated when multi-purpose services were involved. It was difficult to apportion the time spent on family planning and on general public health. Different methodologies have been employed to obtain relatively accurate data on the duration of servicing. For instance, stopwatches or routing slips for time intervals were used in some programmes in the West to measure the amount of time consumed in processing a family planning client. Programmes in the region could experiment with such techniques in the clinic setting on random days of each month. Such techingues would supply a base for determining optimum workloads or for evaluating performance [4].

136. The comparisons of clinic performances often did not consider their ecological differences. Nevertheless, these comparisons remained important in the programmes where they were computed, i.e., in Hong Kong, Malaysia, the Philippines and Singapore. Significant changes over time reflected the need to alter the inputs. Malaysia sought to optimize its utilization of clinic facilities by shifting clinic locations or by combining the resources of more than one clinic after identifying the ones which were overworked or partly idle. A regular analysis of statistics on programme operations could ensure the maximum efficient utilization of resources. Furthermore, the results would be useful for evaluating the impact of field-worker programmes and extension services that had been relatively successful in several countries of the region.

137. Reporting was done in some proprammes on the training of different types of family planning workers and on activities relating to information, education and communication. This is essential for assessing the relative importance of these supportive inputs in contributing to the over-all effectiveness of programme management and motivational efforts.

4/ There was a possibility, though, that speeding up the process might be detrimental to acceptance if female clients viewed the clinic as a location for more than family planning services. The Philippines noted that many clients liked to linger on at the clinics to escape temporarily the demands at home and resented being speedily processed.

The systematic analysis of the number of workers, from doctors to field-workers, receiving orientation and training, the numbers of hours spent in training, etc., holds great value for administrative evaluation. Likewise, the amount of motivational work through meetings, films, printed matter, mass media and campaigns done for family planning should be recorded and tabulated (in time units as much as possible) despite the diversity of media forms. Most programmes collected the source of referral, another relevent input. Face-to-face contact, such as in Korean mothers' clubs or Singapore's *post-partum* contact settings, was known to be more persuasive for family planning adoption than mass media. The latter was more responsible for an initial awareness of family planning. Of the programmes studied here, those in India, Indonesia, Malaysia and Nepal collected some of these details routinely in a quantifiable manner.

138. The document on "data available for input-output analysis" (appendix X) presents the kinds of data available for management-oriented analysis in the programmes under study. Performance indices for each national family planning programme depended upon what levels were designated to be in need of performance evaluation. These were usually not calculated uniformly for each operational level (e.g., individual, clinic, administrative area comprising several clinics, etc). Hong Kong, for example, calculated several indices on welfare workers' performance and one for the clinic (average attendance per clinic hour). Nepal employed an "achievement per staff" score which was based on the conversion of all acceptance onto an "equivalent sterilization basis". Similar indices were employed in Fiji ("percentage protected") and were to be introduced in the Republic of Korea ("total activity index").

B. Feedback

139. The term feedback was used here in a broad sense in that it included the transmission of information from the central evaluation unit to the primary reporting units as well as upward to the policy-making authorities and senior level administrators. Systematic feedback to the reporting units from the central evaluation unit through progress reports was in operation in all countries except Nepal the Republic of Korea and Sri Lanka. Usually feedback came once a month, except in Fiji, where it came quarterly. Comparative performance figures for the reporting units were often provided, but only in a few countries did these details go as far down as the individual clinics. The ranking of the performance of clinics or administrative areas was done regularly in the Philippines, Indonesia, Hong Kong, and Singapore and in Malaysia on an *ad hoc* basis. Other forms of feedback were also available periodically to provide more detailed information on programme achievements.

140. The quarterly summaries prepared in some countries went beyond acceptance figures providing also status reports on other acceptance-related activities. All countries issued annual reports which were usually for general circulation, containing findings from special studies, summaries of annual budgets and expenditures in addition to consolidated data from the routine monthly reports. A large number of charts and graphs depicting performance in previous years, trends in accepter characteristics, etc., were also included.

141. Most countries conducted occasional studies using data from service statistics reports. These included the calculation of births averted through the programme and estimates of new accepters required over a period of time in order to achieve the demographic goals of the programme. Malaysia and Indonesia had a regular monograph series on various aspects of the programme. The distribution of these reports did not necessarily extend to the peripheral levels.

142. Three aspects were involved in determining the ultimate value of feedback: (a) the content, the flow, and (c) the rapidity of flow. Regarding the content of the feedback, there was generally too much statistical material with too little interpretation. When a feedback report's audience was the higher administrator, minister or chief executive, the data, to be useful, had to be understood readily and acted upon quickly. Voluminous statistics demanded too much time for individual interpretation. Generally, it was the task of the chief evaluator to select relevant information and to decide upon the nature and format of its presentation to the administrator.

143. When feedback was directed to the clinic staff, similar decisions were needed on what information was of most interest and of most use. Ordinarily, programme feedback to the clinic included a clinic-specific basis for ranking performance, as mentioned earlier. Evaluators reported that this type of differentiation was helpful in encouraging competition. It boosted acceptance rates as well as produced a general picture of programme performance.

144. The second criterion mentioned on which to evaluate a feedback system was flow, which involved the levels to which feedback reports were distributed. Generally, statistical reports were sent to executive heads, senior programme officials and so forth for their review. Apart from this routine was the subsequent

need to inform the lower levels of operation. In Indonesia detailed feedback reports were sent to the provincial and regency levels, the family planning coordination offices and implementing units. Mention could also be made of India's feedback arrangements, where the central evaluation unit was responsible for disseminating the monthly progress report to all state bureau. Feedback to the districts and family planning centres was each state's responsibility as a programme implementing unit although no thorough check was made on this. It was unlikely that all family planning centres received regular feedback on performance, though it was possible that some states had been able to establish a complete feedback network.

145. Separate mention might also be made of the computer-generated clinic feedback in the Philippines information system. These monthly reports gave a clinic's performance in terms of its accepter recruitment and caseload rankings among other clinics of the same implementing agency and then within the whole national programme. This permitted self-evaluation of achievement. Each quarter the Commission on Population (POPCOM) also provided a static picture of the clinic's coverage, which over time made clinic performance more apparent.

146. If feedback was not available rapidly enough, it could defeat its purpose. Monthly intervals for feedback to peripheral units seemed optimum. The time schedule for submitting summary progress reports to superiors would depend on evaluators' and planners' perception of information needs. In an ideal situation, the rapidity of feedback would exploit at programme's fervour and heighten motivation by demonstrating the positive results of the combined efforts of all programme sectors. It could also identify quickly problem areas in need of greater supervision before they became unmanageable. Rapidity was not only important for the regular feedback reports. Special reports, brief and substantive, could be distributed when critical changes, outstanding achievements or special activities occurred in the programme. This spontaneous, although irregular, feedback could supplement the regular reporting. It would provide each peripheral service unit with some sense of identity with the total programme. It might be noted that in some programmes, e.g., those of India and the Republic of Korea, the strong target system was partially able to compensate for the lack of feedback to the peripheral units.

147. As tabulation and analysis of various aspects of programme performance becomes more frequent, evaluators need to rise above their research orientations to consider systems management and possibilities for improving programme administration. Therefore, open channels of communication should exist between the clinic supervisor, intermediate and higher administrators and the evaluator. Maintaining two-way flows of information could furnish a perspective and create the motivation needed for further progress.

VI. ISSUES RELATED TO THE IMPROVEMENT OF THE SERVICE STATISTICS SYSTEM

148. A considerable amount of discussion by evaluation experts centred upon issues concerning the improvement of the service statistics system. The installation of mechanisms to ensure the validity and reliability of the data and the computerization of the information system to speed up the process were two topics which warranted extra attention. It was also suggested that service statistics might be further developed through their integration with health statistics. Interest in this was especially strong in those quarters where the family planning programme was subsumed under the aegis of the health services. The following discussion is based upon responses from country co-ordinators to questions relating to these three areas.

A. Procedures for maintaining reliability and validity in family planning statistics

149. The reliability and validity of service statistics varied considerably across the programmes involved in this study. Concomitantly, the number of built-in mechanisms available to safeguard their accuracy also varied. Some evaluation units were intent on protecting the accuracy of the statistics by as many means as possible. Others were willing to accept a high but not perfect level of accuracy, around 95 per cent. This was judged to be sufficient for administrative purposes. Nevertheless, it was evident that in all cases validating mechanisms would continue to be necessary to satisfy both the desire for accuracy and the need for reliable up-to-date data.

150. Responses to this study's inquiries about the presence of these protective features revealed a diverse usage situation. It was expected that, within the service statistics system, fundamental checks would be made on the differences between balances of reported accepters and facesheets received (where appropriate) and distributed amounts of contraceptives. In this way, inordinate discrepancies would provoke a follow-up action to identify the source and reason for misreporting. Unfortunately, this was not systematically done, and usually errors were tolerated until they reached serious proportions.

151. Some programmes did attempt to avoid such situations. In the Philippines, a special task force was recruited to monitor inaccuracies in reporting [1]. In Fiji and India, the staff made routine field checks on a sample basis to verify reported figures of either acceptance or contraceptive distribution.

152. The quality of family planning statistics is chronically subject to three main liabilities: deliberate misreporting, over and underenumeration, and incompleteness in recording and reporting. In table 7 the mechanisms in operation in the study countries to counteract these problems have been classified. It was notable that not all programmes had a mechanism to guard against each liability. Also, where present, these mechanisms might not be completely effective in monitoring the quality of the statistics. This would be likely where the safeguard devices were not regularly implemented.

Table 7.
MECHANISMS FOR ASSESSING AND IMPROVING THE RELIABILITY AND VALIDITY OF SERVICE STATISTICS

Problems for data quality	Corrective mechamism and countries where in use
Deliberate misreporting	1. Differences in balances of accepters recorded and reported, contraceptives distributed, revenues (F, Ins, K, N, P, SL) 2. Spot checks (I, Ins) 3. Accepter verification survey (Ins, P) 4. Verification of client registration number (M)
Over-and under-reporting	1. Field checking (I, Ins, M, P, SL) 2. Matching client registration numbers to master list of accepters (M)
Coverage	1. Field checking of recording and reporting (I, N, P, SL, T) 2. Monitoring completeness in clinic reporting through other devices (I, Ins)

Fiji (F)
Hong Kong (HK)
India (I)
Indonesia (Ins)
Malaysia (M)
Nepal (N)
Philippines (P)
Republic of Korea (K)
Sri Lanka (SL)
Thailand (T)

1/ POPCOM maintained a team of 12 research assistants whose function was to inspect, train and assist the recording and reporting of data at clinics whenever necessary. These research assistants worked in pairs and spent an average of four hours in each location correcting problems on which they had been briefed beforehand. It was much like an audit situation but the research assistants were also expected to promote the rapport between the clinic and POPCOM.

153. Falsification in reporting was unfortunately an implicit problem for all programme statistics, and the number of corrective mechanisms present indicated the extent of its threat. The four mechanisms shown in the table were known to be in current use. Fiji and Singapore maintained fairly close supervision over their figures, profiting from the advantages of a relatively smaller and less complex organization. Accepters were verified through surveys in Indonesia and the Philippines. These surveys confirmed acceptance figures and provided continuation rates (assuming that the survey supplied a more reliable enumeration than the service statistics system) [2]. Malaysia used a civil registration number for client identification and was able to verify each accepter's existence. Additional checks were made with a master list of accepter identification numbers to ensure that all the new accepters were *bona fide*. The civil registration number was also recorded in the Republic of Korea and Singapore, and the Philippines was planning to implement a national identification number system for use in its programme. In the case of the Republic of Korea and Singapore, it was not known whether this number was being used to verify reported accepters.

154. Over- and underreporting could be controlled through spot checks and field checks of recording procedures. In programmes where these were used, they were conducted either selectively or completely. For example, in India, a monthly 5 per cent sample of target couple registers was taken to verify accepter characteristics. The sample was selected randomly and systematically by each state's demographic and evaluation cell. The state cell decided which district and which primary health centre's registers would be verified.

155. Field checking was usually the responsibility of the supervisory staff who were located within the implementing agency at an intermediate administrative level, or who came from the central evaluation unit. It would be ideal, however, if consistent and thorough supervision could be available at each level. The training in recording and reporting of service statistics given to the service staff was an indirect, but effective means of avoiding enumeration errors.

156. Other inaccuracies in statistics occurred through incompleteness. Attempts to achieve complete reporting included making salary disbursements contingent on the receipt of clinic reports. This proved to be relatively effective in Indonesia [3] and India. Facilitating the regular clinic reporting was also done by using pre-addressed and stamped envelopes as mentioned earlier. Other forms of direct or indirect motivation more than likely existed to resolve problems in receiving these reports although they were not specifically reported by country co-ordinators.

157. The needs for creating and installing mechanisms for verification were great. The primary reason for them was the need to maintain an accurate picture of family planning protection. The expanding role of the commercial sector continually altered this picture and called for broader coverage in reporting. Data on continuation, method switching and transferring between programme and non-programmes sources influenced the scope of the national programme with respect to the public's acceptance of birth control. Within the programme, deficiencies in the service statistics system were tolerated, usually because of the increased workload of the evaluators. However, accurate reporting is essential for programmes with fixed accepter targets (as in the Republic of Korea) or an incentive system, as their financial outlays stand to be affected. Finally, reliable information on the actual accomplishments of the national programme was needed for higher administrators to convince themselves and others of the programme's effectiveness. Reasonable accuracy, therefore, was a functional requisite for any service statistics system to ensure that each accepter and her or his use of a birth control method were facts. With it, the aggregated statistics became a reliable base upon which to estimate protection achieved through the programme.

B. Computerization of the system

158. The role of the computer in programme evaluation, presupposing the availability of facilities, was discussed by the experts and programme administrators. The situation of computer use was quite diverse. In general, earlier generation computers and the newer limited-capacity computers were available at a relatively low cost in the developing countries. However, the decision to invest in a computer involved major problems. They centered on the ability to meet the essential needs of maintenance, trained manpower and sufficient workload [4, 5].

2/ One case where follow-up surveys might have suffered an undercount was in the Philippines. Catholic accepters were thought to be somewhat reluctant to admit contraceptive use.

3/ As a result Indonesia enjoyed 97-98 per cent completeness in reporting.

4/ George E. Immerwahr, "The role of the computer in family planning research and evaluation", *Evaluation of Family Planning Programmes* (United Nations publication, sales No. E. 70. II. F. 20), pp. 90-95.

5/ "Computers in less developed economies", *Finance and Development*, Washington, D.C., vol. 8, No. 1 (March 1971), pp. 2-6.

159. From the co-ordinators' replies, it was seen that Indonesia and the Philippines used computer facilities to process their service statistics, while Singapore and Malaysia were in the stages of installing computers for programme use. Of the remaining seven countries, five (Fiji, Hong Kong, India, the Republic of Korea and Sri Lanka) did not envisage a need for computerization in the near future. In Nepal and Thailand, the matter was under consideration. The negative replies were taken to mean that the need for a computer was not sufficient to warrant its use.

160. It was generally agreed that computers were not appropriate for every programme situation. In places such as Fiji, Hong Kong, the Republic of Korea and Sri Lanka, the programmes were able to handle their present volume of statistics either manually or with the aid of unit record machines. The Republic of Korea's service statistics system made some use of electronic tabulation, as did Singapore. For most countries, sophisticated tabulations and analyses were not conducted regularly enough to justify the purchase and maintenance of a computer. With respect to accepter characteristics, cross-tabulations were not required very frequently, since few changes occurred in short periods of time, and the analysis of acceptance data could be handled with simple machines.

161. The decision to computerize a service statistics system is a multistage process which involves meticulous deliberations at each step. First, the desirability and need for computerization has to be determined. This includes quantitatively assessing the advantages and capabilities of a computer to meet the programme's needs of statistical analyses and evaluation. The obvious asset of a computer is the quick turn-around of data input into output. Its capacity for multi-operational processing makes it highly attractive as it increases efficiency by decreasing time and manpower consumption. However, its expediency has to be considered from within the programme's context -- is the present service statistics system mature enough in terms of its recording and reporting procedures to be processed electronically? The procedures would need to be well established, and the format of the records and reports would need coding adjustments.

162. Aside from the technical proficiencies of a computer, another issue involved in contemplating computerization is the question of data accuracy and completeness. This poses a substantial problem to most service statistics systems in the ESCAP region. Computerizing the system might furnish internal consistency checks, but the quality of the data would have to be guaranteed first. Misreporting in the enumeration of accepters is a major constraint to computerizing the tabulation. A sophisticated and expensive tool is of little help if the materials are not reliable.

163. Maintenance of the computer in developing countries could also cause additional problems. The cost of a computer would obviously supplant other expenditures. The initial outlay is often an investment which most cannot afford or do not consider essential unless certain of the subsequent benefits[6]. The assurance of supportive resources -- trained personnel to operate and maintain the computer, a stable power supply, physical facilities to house the computer and supplies (such as cards, tapes, discs) -- is necessary. If the computer malfunctions, the availability and speed of repair services are decisive factors for guaranteeing smooth functioning. Availability of trained personnel is also important for continuous programming and processing of programme statistics analysis.

164. Maximum return on the cost of operating a computer requires a sufficient workload. One resolution to this work-capacity problem is to have a computer service all or a considerable number of government ministries. All health and social welfare bureaux might utilize one computer to process their statistics, and thus mutually benefit from its presence. Another alternative is to enter into a contractual agreement with a private data processing firm and use its computer services. The former situation occurred in the Philippines, where the National Computer Centre assisted the data processing for the Population Commission on a cost basis until recently and the latter was the arrangement in Indonesia. For most other programmes, unit record data processing machines were able to satisfy the need for rapid analysis.

165. Where a computer was likely to be installed or was at present in use (e.g., Indonesia, the Philippines, Malaysia and Singapore), the establishment of a central accepter file came under consideration. This file involved the central maintenance of all accepter records for evaluation and follow-up purposes. Accepter characteristics, family planning practice and follow-up information would compose the bulk of these data, which could be sorted in the computer and updated periodically. The value of the file lay in its ability to provide a cross-sectional picture of the programme, and to identify "delinquent" accepters at any point of time. However, it should be noted that the accepter file could also become less representative of total contraceptive practice, as the commercial sector's role enlarged over time.

6 Related to this is the realization that developing economies need to promote full employment, in which case automation could be counterproductive.

166. Unfortunately, the efforts required to maintain accurate and up-to-date records of all accepters on a computer detracted from the theoretical appeal of the file. Firstly, for the purpose of deriving evaluation-oriented information, such as current contraceptive continuation rates, from a computerized central file, the records needed to be constantly revised as the accepters received additional family planning services, switched methods or dropped out. This perhaps could be done on a sample basis as is done in the Philippines; however, there is the danger that the sampled accepters might receive more attention from workers than the remaining ones, which could presumably inflate continuation rates obtained from the sample data. Alternatively, periodic follow-up surveys or accepter verification surveys, properly conducted, might prove to be more cost-effective for evaluation purposes.

167. The other advantage of a computerized central accepter file, that of identifying "delinquent" accepters (those who had missed appointments or discontinued practice) automatically for immediate follow-up, would be a definite aid to clinic workers and would be practical in developed countries, where modern means of transportation and communication existed. Unfortunately, it would not be immediately applicable to most areas in the ESCAP region, since monitoring accepters to this extent would place a heavy burden on the field personnel. It would entail dispatching them to remote areas in search of missing clients, whose addresses were often not reliable.

168. It appeared that, while a few countries in this region might be equipped and committed to managing a central accepter file, most were not prepared to undertake such a project at their present stages of programme development.

C. Feasibility and desirability of integrating family planning statistics systems with health statistics

169. In discussing the integration of family planning statistics with health statistics, the degree of programme integration first had to be considered. Integration could occur at many levels, e.g., programme objectives, staff functions, buildings and equipment, record-keeping and reporting, as mentioned earlier. On a formal basis, at least half of the study countries had a non-integrated set-up; however, operationally speaking, their service efforts had been combined.

170. A brief overview shows that the delivery of family planning services was made through the health and/or MCH infrastructure in Fiji, Hong Kong, India, Indonesia, Singapore, Sri Lanka and Thailand. In Nepal, family planning and MCH services were parts of the same project. In the Philippines, the majority of the family planning clinics were operated by the Department of Health and the Institute of Maternal and Child Health, which were already providing other services when the official family planning programme began there. The Malaysian programme relied upon the health infrastructure in some areas, but planned to cover all of rural West Malaysia with the integration of family planning with rural health services wherever possible. Use of the health infrastructure was minimal in the Republic of Korea, where the major part of medical services for family planning was provided by private physicians on a piece-rate payment basis. A complete integration project was underway on an experimental basis in Indonesia. After a trial period, the integration of basic health services and family planning services was in operation in Thailand, where attempts were being made to incorporate the family planning programme in a rural family health programme, whose personnel would then be responsible for MCH, family planning and school health services.

171. The functions and service approaches differed for the health and family planning programmes. The health enterprise, particularly MCH, was supposed to provide adequate health services to families as a whole and to maintain adequate health standards in the community. Its service orientation contrasted with the accepter-recruitment orientation of family planning programmes, which aimed to reduce excessive fertility levels. Under these conditions, the priorities involved in the administration of the programmes differed, although both engaged in preventive forms of health care.

172. By operating within an integrated framework, a composite staff of both health and family planning personnel might need to have their job priorities redefined. At the clinic level, family planning service efforts could dissipate under the combined programme objectives if they were not equally encouraged and supported by the supervisory staff. Country co-ordinators of the present study suggested that the less popular family planning field-work ran the risk of being neglected by an integrated staff, unless it was incorporated as part and parcel of health extension efforts. For example, Philippine evaluators found that the family planning performance of the multipurpose workers at the rural health centres was lower than that in the single-purpose clinics. Further, worker inputs could also be affected if the family planning accepter targets or immediate health goals placed disproportionate demands on their time and energies.

173. The administrative advantages to be incurred from merging the services would then depend on the degree of co-ordination and co-operation in programme duties. It was assumed that with programme integration, the services for both health and family planning would be located at the same clinic or health centre. If this was not the case, then a reliable referral system was necessary to co-ordinate the work. Such a network would ensure that each client receiving health treatment who was also in need of family planning information would receive it through reference either to an appropriate clinic or to a field-worker. The absence of this kind of communication and collaboration between the two programmes would detract from their accomplishments.

174. Concern was also voiced over the extent to which integration would aid the services in both programmes in a practical sense. Most countries agreed that if both programme infrastructures were not equally developed, integration might be mutually detrimental. They also agreed that the question of integration was not really relevant except when family planning was already part of the health services. Until recenty, the development of family planning usually had a history of independence from government sponsorship. International funds were more readily available for family planning than for health, which added to its peculiar status among other national programmes. In several cases these circumstances evolved separate budgets and supervisory instruments. As a result, the question arose as to whether integration might not lead to a decrease in government emphasis on family planning.

175. Although the extent to which full-scale integration would be mutually beneficial to the two programmes was debatable, a few countries supported the incorporation of some MCH information in family planning records in order to reduce the time consumed by routine registrations. The combined record-keeping schedule would allow the data to be located centrally and facilitate the retrieval of client forms at the service unit level. The time required for monthly reporting on both family planning and health services would also be shortened.

176. At the time of this study, separation usually existed between the records and reports for family planning and those involving health services, even where these records were maintained and submitted by multipurpose workers. The flow of these reports and their ultimate destinations were generally different irrespective of whether both destinations were under the same (health) ministry. In Fiji, Nepal, and Sri Lanka, some degree of integration existed within the recording and reporting systems. Fiji collected both MCH and family planning data on the family record card, and a single report was sent up the administration hierarchy. In Nepal, separate records and reports existed for family planning and MCH under the same statistical system, which was different from that for other areas of health. Sri Lanka used the same statistical system for MCH, public health and family planning from field to central level. The records and reports for each component were distinct, although some MCH information was included in the family planning reports. In Thailand, however, the area of evaluation of the comprehensive rural health programme was separated from family planning evaluation although the two programmes were completely integrated at the service level. The study showed that generally the reports produced for family planning were not integrated with those for health, although they might some time be produced by a composite evaluation unit.

177. A family folder system was suggested by some country co-ordinators in which all relevant medical histories, health needs and family planning practice information could be incorporated and kept up to date. Centralizing the maternal health and family planning details on the mother was one advantage of the folder scheme, in addition to its obvious function of covering all family members. Couple protection through contraception would also be immediately visible regardless of which spouse was the user. Given the availability of the necessary staff, home visitation could also be more easily organized and prepared from these folders. A workable registration number for both health and family planning services might be instated that would allow for clinic and family identification for recording future follow-up data. Needless to say, this would require much higher doctor/population and nurse/population ratios than were found in most countries, as well as the propensity on the part of the population to utilize available health facilities fully.

178. In the final analysis, the integration of family planning statistics with health statistics was viable if the quality of existing health statistics was on a par with that of family planning information. Most countries acknowledged that their health statistics were less developed than those collected in the family planning programme, which made the subject of statistical integration less feasible. In any event, evaluation research on the programmes followed

separate directions of interest. The gross differentiation of the two programmes – health services were oriented towards mortality and morbidity control, while family planning directed its efforts towards fertility control— demarcated the areas for evaluation.

179. The issue of integration of statistics also involved consideration of the audience for which the reports were made. It was assumed that a report with statistics on both family planning and health would be read by an administrator who was directly responsible for implementing the two programmes. If the channels of action were such that they could make full and efficient use of the statistics, then integrating the data would be expedient. The decision to steer a national family planning programme's course towards autonomy or towards integration with health services ultimately determined the usefulness of integration of the two statistical systems.

VII. SUMMARY AND CONCLUSIONS

180. The goal of this study was a detailed examination of the existing components of the family planning service statistics systems and their utilization in 11 countries of the ESCAP region. Although it was hoped in the beginning that a thorough assessment of the strengths and weaknesses of these systems could be made, it was found that to do so on a country by country basis was not feasible within the resources of the study. However, the detailed examination helped to bring out certain important characteristics generally observed in the systems studied.

181. The descriptive character of this report perhaps belies the amount of analysis undertaken. A comparative study could be done only after the information systems were examined in detail. This required a close scrutiny of concepts and definitions used in programme evaluation, recording and reporting forms as well as the tabulation and analysis of their contents, feedback procedures and other components of the systems, the findings of which have been outlined in the annexes to this report. No attempt, however, has been made to suggest standardized formats for recording and reporting, for reasons stated later in this chapter. The report has attempted to present the uniformities as well as variations among the different service statistics systems with respect to some of their crucial elements. The discussions contained in the report underscore certain important desirable attributes of the systems, although they have not necessarily been stated in the form of specific recommendations.

182. It is hoped that this report will serve as a source of information on the records and reports and their movements in the various service statistics systems. Programme evaluation authorities could use this information in relating their own evaluation situations to those of others. An attempt has been made to bring out the highlights of the alternative forms and procedures existing in the programmes so that administrators interested in improvement of the system can make use of them. The results of the study could also, it is hoped, direct ESCAP in its programme of assistance to countries of the region with a view to more effective family planning programme evaluation.

A. Service statistics system as a programme component

183. The analysis of any network necessitates a prior consideration of the context in which it operates. The information requirements for a family planning programme and the capacity of the service statistics system to provide this information need, therefore, to be examined against the background of the entire programme. An examination of the programme backgrounds brought to light substantial variations in the structures of the family planning programmes studied. It was observed that related internal and external factors defined the limits of programme services as well as the possible dimensions of resource inputs. Under given socio-economic, geographic and demographic situations, other factors that affected the total use of contraception, over and above those documented through the service statistics systems, included commercial sales of contraceptives, work done by voluntary organizations and involvement of private physicians in providing family planning services.

184. The organizational arrangements of a national family planning programme, particularly the degree of autonomy accorded to it in implementing the programme, were seen to affect its implementation strategies. These, in turn, influenced the systems of data collection and transmission required for programme administration. Other factors that influenced the content and coverage of these systems included the levels of maturity and consistency achieved in certain programme elements such as training, communication and motivation activities and delivery of service; the number of administrative hierarchies in the programme; and existence of output targets for workers or clinics.

185. The sum total of the information embodied in service statistics ensures certain levels of awareness of programme progress at service and administrative centres by providing the information needed to monitor trends in acceptance, to pin-point areas of resource shortages and to identify the accepters, users and discontinuers. Among the programmes studied, this awareness varied according to the extensiveness of the service statistics network, the contents of the recording and reporting forms and the care taken in the analysis and interpretation of data. The formats of the records involved in the system generally reflected the amount of concern about the client and the clinic operations. This concern was further punctuated by the requirements and procedures for reporting, specifically with regard to what information was transmitted. The tabulation and analysis performed routinely on these data shaped the final reports and their interpretations eventually presented to the heads of programmes. This process was thus greatly dependent upon the amount and type of information selected from the records for reporting and subsequent analysis.

186. Various international organizations, research institutions and donor agencies have attempted in the past to develop standard formats for data collection and reporting for family planning programme administration and management. The present study indicated that, although broad similarities existed among the programmes with regard to the type of data collected and the purposes for which they were ostensibly used, standardization of recording and reporting systems among programmes did not appear feasible in the immediate future. Some of the major reasons for this were:

(a) There was a lack of uniformity among nations with respect to implementation strategy and consequently the extent to which uniform types of service statistics could be generated routinely;

(b) The potential for accuracy of content and completeness of coverage varied among countries, often because of factors beyond the control of family planning authorities;

(c) The volume of statistics collected and the amount and types of analysis undertaken depended upon the capabilities, which varied among the programmes, of the evaluation office entrusted with such responsibilities;

(d) The amount of change required for adaptation to a standardized data collection and reporting system might itself inhibit an old and established system from attempting such an endeavour, unless the gains from such change far outweighed the inconveniences.

187. On the other hand, achieving regional comparability in reporting of certain important input and output statistics was desirable for various reasons. One likely by-product of such comparability was that international demand and use of data might provide an incentive for improving their quality.

B. Terms and concepts

188. An examination of the terms and concepts used in family planning evaluation showed that several of them were used with more or less coinciding definitions in the countries under study. However, there were many other terms whose meanings differed among the countries, largely owing to differences in the programme context. Equally true was the fact that in a few cases different terminology meant the same thing.

189. Some major terms, e.g., acceptance status, ranged from having very specific to very general definitions among the programmes studied. It was surmised that the degree of specificity in the definitions used in a programme reflected the level of development of crucial elements of the programme. Furthermore, the degree to which acceptance status and other related terms were defined in the programmes indicated differential concern for estimating the actual use of contraception.

190. Definitions of the terms used in the programmes were originally requested from each study country with the intention of attempting to develop standardized definitions. However, it was later felt that identifying parallels between countries in respect of the meanings attached to the terms would be a more useful endeavour. In this connexion, elements common to the definitions of each term were extracted, isolating the differences in each national programme for independent examination. This exercise provided the normative interpretations of several crucial terms which could be of assistance in understanding the nature of the programme and assessing its performance in the countries of the region. This comparative analysis also indicated that while standardization of certain crucial terms used in evaluation was both feasible and desirable, a large number of others were closely linked with the peculiar situation of each individual programme, and consequently not easily amenable to standardization.

C. Contents, flow and processing of statistics

191. Multifarious forms were used in the recording of activities and performances. Records relating to the client, to clinic operations and to other programme functions varied among the programmes with respect to numbers and content. Reporting procedures also varied in terms of the information transmitted, the intervals for reporting and their destinations. The inevitable conclusion arrived at after examining these procedures, was that the amount of paperwork involved in maintaining the existing service statistics systems needed to be streamlined. Indirectly, this meant working towards reducing in volume the type of information generally requested for evaluation at present. This would, in fact, be a justifiable recommendation in view of the following:

1. It was necessary to place restraints upon the amount of analysis done on acceptance records, because of the generally limited research capacities of evaluation units and because the routine tabulations and analysis themselves consumed much of the available manpower;

2. Co-ordinating implementing agencies regularly became a priority, particularly where several were covered by the service statistics system.

3. Feeding back information to upper and lower levels would require further analysis and interpretations meaningful to the audience; and

4. Finally, the quality of the data was a foremost concern, and monitoring their accuracy was continually necessary.

192. It was also noticed that certain records and reports used mainly for control purposes, such as those relating to finances or supplies, were outside the purview of several existing service statistics systems, although they were highly relevant to programme evaluation. Even in programmes where management and evaluation functions were isolated from each other, evaluation units could be of greater assistance to the management if the former were regularly fed with pertinent information which was otherwise considered to be of a purely administrative nature. Proper utilization of such additional information would, however, require evaluation units to shift their orientation from conventional types of analysis.

193. A recurring observation in the examination of most of the service statistics systems was that the amount of information reported by the primary reporting units (e.g., clinics) comprised a small fraction of what was routinely generated or was otherwise available at the reporting unit level. It must, however, be acknowledged that some of the available information, such as that relating to medical examination findings, was required primarily for use at the clinic level and did not need to be reported to higher levels. Nevertheless, there was still scope for reporting additional useful information, especially on finances and other inputs, to the central evaluation units. Again, the reported and often were not subjected to the kinds of analysis and interpretation which could have been of value to the management.

194. Even though there was considerable scope for improving the existing service statistics systems, they still served a useful function. In answer to questions on the extent to which service statistics had been useful in the past in influencing policy decisions, it was found that problem areas of programme implementation, especially of clinic performance, were generally identifiable from the service statistics. Indonesia, Malaysia, the Philippines and Singapore noted that their findings had resulted in corrected, intensified inputs or alternative implementation procedures. In Hong Kong and India, integrating health and family planning services through post-partum recruitment aided the family planning cause. In other countries, some policy decisions, such as promoting particular contraceptives, were derived through the analysis of service statistics. When IUDs began to lose popularity in Hong Kong and Singapore, the programmes relaxed their emphasis on the method and turned to other methods.

195. Efficiency in the use of time could be substantially aided by the computerization of the information systems. However, several major constraints operated against its full-scale adoption by many programmes at present. Furthermore, the present levels of activity of the evaluation units did not fully justify the heavy initial investment in electronic data processing, unless it was done on a time-sharing basis. It was expected that all programmes would eventually use electronic tabulation and processing when the service statistics systems were sufficiently stabilized and management-oriented data were systematically collected and utilized.

D. Integration of health and family planning statistics

196. The feasibility of integrating health and family planning statistical systems was considered in this study by inviting opinions of the evaluation chiefs of family planning programmes on the subject. Such integration, where possible, could alleviate the additional burden of separate recording and reporting tasks. Besides, certain health data, particularly those relating to maternal and child health, could be of value to family planning programmes both at the recording and at the data analysis stages. It was felt, however, that the disadvantages of combining health and family planning statistical systems far outweighed the advantages in most countries at the present moment. Some of the major reasons were:

(a) Several family planning programmes were operating under authorities separate from those of health. Even where the highest authorities were the same, the two programmes were bifurcated in terms of budget and administration.

(b) The levels of development of health and family planning services differed in most countries. Where health services were not as well developed as family planning, combining their statistical systems would be dysfunctional to family planning management; and

(c) The clientele for the two kinds of services were often different. For example, male recipients of family planning service were often unlikely to be covered on an individual basis by health services in most developing countries. A family folder system for the entire population would be a desirable, but at present perhaps impractical, way of combining health and family planning records.

E. Recent changes in the scope of service statistics

197. The dynamics of the evolution of family planning programmes is marked by the changing information needs for their administration. In the past, emphasis was placed on reaching and informing the potential accepters as well as on persuading them to adopt family planning methods. This focus on accepters was reflected in the reporting and analysis sequence,

which concentrated on accepter profiles and acceptance enumeration. Even performance indices for workers or clinics were based on numbers of accepters.

198. Administrators are now increasingly realizing that the number of accepters cannot substitute for the quality of acceptance measured in terms of continuation of contraceptive use. Further, continuation of use has usually been estimated through periodic follow-up surveys, and mainly for the purpose of measuring programme effectiveness. However, early discovery of a change or a sudden drop in the use of a particular method is essential for appropriate corrective action. Follow-up surveys are not of much use for this purpose. Thus, the need to develop reliable techniques to monitor contraceptive use through the service statistics system is of foremost consideration.

199. Another discernible shift in the concern of administrators in recent times has been from effectiveness to efficiency in implementing family planning programmes. There have been massive inputs into the programmes in terms of financial, material and technical assistance from both government and external sources. Application of scarce national resources to family planning needed justification in terms of output for the input expended. This need, along with the increasing maturity of programmes, has resulted in a tendency on the part of programme planners to re-evaluate programmes from the point of view of gaining maximal returns from the inputs. Service statistics systems should therefore be geared to providing data that satisfies this need for monitoring programme efficiency.

200. Although they are not fully part of the routine in the service statistics systems, indices of efficiency have been experimented with in several national family planning programmes. More efforts in this direction continue to be made in the region by national programmes with a view to making better use of the resources of service statistics systems for managerial purposes[1].

201. A third area to which service statistics systems should devote additional attention is that of non-programme contraceptive use, particulary through commercial channels. The accepters found in these channels have been growing in number in most countries. Irrespective of whether commercial channels are thought to compete with national family planning programmes or to complement them, their contribution can no longer be taken lightly. Not only is knowledge of these contributions needed in order to estimate total contraceptive use in the individual countries, but also the pattern and volume of non-programme contraception could suggest modification in programme strategy resulting in more efficient use of resources. Each service statistics system should therefore devise ways to obtain and analyse such information as part of its normal activities.

202. In conclusion, it may be said that service statistics systems should maintain a certain degree of built-in flexibility in their operations to adapt themselves to the changing needs of the programme. This would facilitate the strengthening of the administrative cities in the programme and contribute to the ultimate achievement of programme goals.

1/ One such attempt is a comparative study of input-output relationship in family planning programmes in four countries, India, Malaysia, the Philippines and the Republic of Korea, in collaboration with ESCAP, in order to develop and test efficiency indicators which could be used by programme managers.

ANNEX I

QUESTIONNAIRE FOR THE STUDY

A. General Programme Information

1. Please give a brief history with exact or approximate dates of the evolution of the national family planning programme of your country to its present form, bringing out especially
   (a) Chronology of major steps or events in the early development and extension of the programme
   (b) Functions performed by voluntary agencies at different times
   (c) Role of international organizations, including financing
   (d) Important legislation or executive decisions
   (e) Intensification of inputs
   (f) Introduction of different contraceptive methods into the programme
   (g) Extent to which the programme is target-oriented
   (h) History of when "first"s of different programme elements occurred
   (i) Phased approach, if any
   (j) Any other important aspects
2. Please provide a description of the programme as it is now, giving coverage of the country by different programme elements such as service; training; education-information-communication; methods available through the programme as well as outside it; whether each method is available free, with incentive or compensation, or payment; special periodic concessions; etc.. Also describe special programmes such as hospital post-partum programmes, programmes run by industries or other organized sector, integration with MCH programme or other health programmes showing what kind of integration has been effected and at which operational levels, etc.
3. Policy statements:
   Please attach English translations of the official legislative documents or policy declarations upon which your national programme is based. If English translations are unavailable, please send copies of the various documents in your official national language (s).
   Please also include statements regarding population or family planning policy goal and objectives made in the various five-year (or other long-term) plans.

B. Organization and Personnel

1. Administration and organization chart
   (a) Please describe the current family planning administration and organization with charts for central, provincial and lower levels as of 1 January 1972, together with explanatory texts where necessary. Please briefly indicate the nature and timing of major reorganizations in the past.
   (b) Please indicate the number of units (boxes as shown in the organization charts) of each type at central, provincial and lower levels. Please also indicate the average population per unit at the lowest (service) level.
   (c) Also indicate separately the location of evaluation unit (s) at each level.
2. (a) Corresponding to the organization chart (s) given by you, please indicate the approved staffing pattern at each level, and within each unit.
   (b) Please also indicate which categories of staff are expected to work in close contact with the public (this means generally staff actually providing service, education, information, etc., and the immediate supervisers of such staff). Also indicate what population size is expected to be serviced by each category of staff.
   (c) Please specify the principal duties of each category of service or extension staff.
   (b) Please add explanatory notes to indicate the supervisory relationships among the staff within each unit, noting the supervisory set up obtaining when supervisors are responsible for more than one unit or level.

C. Personnel Table

Given below is a dummy table which, when filled in, will provide an inventory of various major categories and subcategories of family planning personnel in the country working at the peripheral level. Please provide a nation-wide picture of service personnel by filling in this table. If some

categories of personnel are superfluous for your country, please ignore them, and, if some other categories have not been included, please include these. For each category of staff please indicate (i) total number of posts approved or sanctioned, (ii) total number of personnel actually in position on 1 January 1972 (iii) among those in position, the number who have received any kind of training in family planning.

Add explanatory notes wherever you feel necessary, and give some idea of rural-urban distributions of family planning personnel.

	Number approved or sanctioned	Number in position on 1 January 1972	Number trained
(a) Direct service personnel employed through the national family planning programme budget.			
(i) Personnel attached to hospitals, clinics, health centres, subcentres or other static units (exclude field-workers or other field personnel who may report administratively to clinics but woh spend a majority of their time in conducting home visits or other field activities)			
Doctors			
Male			
Female			
Nurses			
Nurse aides			
Trained midwives			
Untrained midwives			
Health educators			
Social workers			
Clerical staff			
Drivers			
Maintenance staff			
Other (specify)			

(ii) Field personnel (include field workers who report to clinics but who spend a majority of their time in conducting home visits or other field activities—use categories similar to those above in so far as they apply)

(iii) Personnel attached to mobile units (use categories similar to those above, in so far as they apply)

(b) Multipurpose government-paid personnel who spend at least 10 per cent of their time on family planning
(Please fill in categories yourself.)

(c) Direct service personnel licensed or otherwise designated by the Government to perform family planning services on a fee-for-service basis (e.g., receive incentive payments for inserting IUDs, giving physical examinations, performing sterilization, recruiting new accepters, etc.)

Doctors
Male
Female
Field-workers, motivators, canvassers or other finders
Male
Female
Other (specify)

D. Family Planning Targets

1. Does your programme employ some form of target system?
2. Are the targets an official part of the five-year (or other period) economic plan?
3. Are targets first set in terms of birth-rates, births averted, couple years of protection or number of accepters?
4. Who sets the annual targets?
5. What specific factors are taken into consideration in setting targets, and what is the exact procedure?
6. Since when did the family planning programme become target-oriented?
7. Which kinds of evaluation staff have a role to play in target setting or allocation of set targets to various areas? What roles do they have?
8. Is the total target divided among various programme contraceptive methods? How is this done?
9. In some countries targets are adjusted annually or from time to time. Are adjustments ever made in your country? Under what circumstances?
10. If the targets have been changed, please attach a table similar to the one in the next page showing the official targets prior to each change. Please give the date of each change, and, if not already indicated, please indicate the reason for each change.

11. Are the targets subdivided by province or area?
12. According to what criteria are the targets allocated to provinces (i.e., population, married women 20-44, etc.)? If there is a formula used, please state and explain it.
13. Do some provinces or areas receive a higher or lower than proportionate share of the target according to the criteria? If so, why? (E.g., rural areas might receive a lower than proportionate target if the population is widely dispersed or otherwise inaccessible, or if it is more difficult to obtain accepters in rural than in urban areas.)
14. Do the provinces in turn allocate targets to counties or other smaller areas? By what criteria?
15. Are there special targets in addition to those allocated by province or area for large hospitals, mobile units, private family planning association, etc.? Please explain.
16. Are targets given to individual family planning workers?
17. If so, is the performance of workers assessed against targets? If so, are the workers aware of the assessment? How long after the end of a month the performance of a worker for that month is assessed?
18. If a worker fails to meet the target for several months, what can be done (i.e., are there sanctions for failure)?
19. Can a worker be dismissed for consistent failure to meet targets, or do civil service regulations or cultural traditions prevent this?
20. Has any worker ever been dismissed for consistent failure to accomplish targets? About how many were dismissed last year?
21. Please attach a table showing the allocation of targets to provinces or other large areas for the current year (or for last year if not available for current year).
22. Is the target system flexible or inflexible (i.e., if a worker falls below target for one contraceptive method, can this be compensated for by over achievement in another?)? If yes, please explain.
23. Please complete the table below showing the annual (or other period) targets by method (if so subdivided) for the last five years or since the beginning of your programme, whichever is later. Please put an asterisk (*) by the years which are terminal years of the various economic plans. If any of the contraception targets are in terms other than family planning accepters, please note which ones and note the units (e.g., users rather than accepters or supply units such as cycles or dozens.) Please draw a slash (/) for years or columns which are inapplicable. If your targets do not fit into the format shown, please attach a separate sheet showing them with appropriate explanation.
24. Please give a similar table specifying actual achievement by method over the same period.

National Family Planning Programme Targets

Year	Rate of population growth	Crude birth-rate	Target accepters by method						
			Total	IUD	Pill	Sterilization		Condom	Other (specify)
						Male	Female		

E. Budget and Finance

1. How are annual budgets planned, scrutinized and approved? Who are the agencies and officials involved in this process?
2. What are the levels within the implementing agency involved in preparation of budget?
3. To what extent are evaluation personnel involved or consulted during preparation of budget—both at national and provincial levels.
4. What other agencies are involved up to the stage of final approval of budget?
5. How is the money approved actually disbursed to the implementing agency?
6. Are there time lags in actual availability of funds to the extent that they affect programme activities? Please give illustrations.
7. How are *ad hoc* arrangements made to overcome such time lags?
8. What are the main heads and subheads under which budgets are prepared at each different level of operation?
9. To what extent is reappropriation from one head/subhead to another possible at each level?
10. What is the system of auditing and accounting?
11. What if any are the charges for services and supplies for each method and type of service?
12. What proportion of the budget is allotted for incentives? To what extent is this amount utilized? What is the amount of various incentive payments?
13. What fraction was the family planning budget of the total health and family planning budget and of the total national budget during the last 10 years or since inception of the family planning programme?
14. Please give budgets and expenditures on family planning for the last five years by each major head and subhead and by source of financial input (national sources, international assistance agency-wise, receipts from charges for services and supplies, etc.)
15. Have any cost-analyses on family planning been carried out?

F. Definitions of Key Terms and Concepts

There are certain terms which are commonly used in family planning programmes. However, they often mean different things in different countries. Given below is a list of such terms, which are by no means exhaustive. Please describe how each term is understood in your programme. If some of these have official definitions in your programme, please quote them. Please also add any other terms and concepts to the list if you feel they are relevant.

(a) Clinics/health centres/subcentres: full-time/part-time, mobile/static, mobile teams with fixed clinic locations, camp, etc.
(indicate working hours, requirement of specific staff and other criteria such as operation theatre and methods given.)

(b) Family planning worker: of each category (e.g., doctor, nurse, midwife, health inspector, health educator, family planning field-worker: full-time/part-time, salaried/piece rate, etc.).
Give designations, and qualification needed: medical/paramedical/non-medical.

(c) Voluntary agencies/organizations (which workers are paid, and what amount of voluntary work is done by whom).

(d) Information/education/communication media.

(e) Categories of contraceptive methods (mechanical/chemical/hormonal/surgical/traditional/natural/conventional/folk method)

(f) Motivator (types, job functions, salary/fee,), other terms such as "finder" (meaning a person who brings in a "case".)

(g) Doctors (public/private, with degrees/licentiate/certified doctor.

(h) Systems of medicine: practice by doctors—modern Western medicine/homeopathy/Chinese–Hindu–Muslim systems/indigenous system.

(i) Various administrative levels or hierarchies (such as state, district, block, primary health centres and city wards, in India or province, **gun, eup or myun, dongs,** etc., in Korea), give approximate average population size.

(j) Accepter (types of accepter—when is a person considered to be one, new/old accepter, etc.), user (regular/irregular).

(k) Eligibility criteria for use of specific methods.

(l) Eligible couples, target couples.

(m) Drop-out / discontinued user

(n) Incentive/disincentive/compensation: who gets it (doctor, motivator, client) for what and how much.

(o) Multipurpose/single-purpose worker (which categories are they and what functions the multipurpose workers perform other than family planning).

(p) Equivalent sterilizations: Is there any other concept used in your country for providing a common denominator for various methods?

(q) Couple years protected (how calculated?).

(r) Any other key terms or concepts used in your country which you feel would be relevant for this study.

If the definitions of certain terms have been revised over time, please indicate what led to such revision. This information is likely to be of importance for countries now embarking on national family planning activities.

G. Evaluation

1. Please locate the programme evaluation unit (s) on the family planning organization chart (s), at each administrative level applicable to your country.
2. Please draw up a detailed organization chart of the evaluation unit at each level, giving the location and number of the various categories of personnel in the units. Please also indicate how many personnel in each category were in position on 1 January 1972. When did this particular organizational pattern come into being?
3. Please describe briefly:
   (a) The prescribed educational and other background, and
   (b) The prescribed activities,
   of each kind of personnel.
4. If the personnel in the evaluation units are sometimes used for activities other than those prescribed in addition to normal work, please describe them. Similarly, if some of the prescribed functions are not actually performed by them at the present moment (as of 1 January 1972), please identify these functions, giving reasons if possible.
5. (a) Did these personnel receive any kind of special training (such as short courses or other in-service training) for their specific jobs either before or after they were recruited? Please give a brief description of the kind of training usually given to them. If possible, also indicate how many had received such training as of 1 January 1972.
   (b) Did anybody receive long-term training in demography or family planning evaluation either in the country or abroad?
6. If some categories of positions have been created for three years or longer, it is desirable to obtain some idea of the turnover rate for these positions. Please provide whatever data you can on the rate of personnel turnover or on the number of changes within the past three years or on the average duration of tenure in each position.
7. What aspects of the programme have been attempted to be evaluated in the country or parts of it (such as over-all programme strategy and administration; clinic efficiency; service; training; information, education, communication activities; knowledge, and attitude practice aspects; continuation rates and costs)?
8. What kind of evaluation research has been used for this purpose (observation studies, case studies, field surveys, analysis of available routine statistics, site visits, etc.)?
9. Have any of the key programme decisions reflected evaluation findings or findings of research studies? Please give a few major illustrations, citing the general findings that led to the decisions.
10. Please specify the various agencies, both local and international which have been involved in evaluation activities or have undertaken major evaluation studies. If there is more than one agency or office of a particular type, please specify their number.
    In the case of international agencies, please specify the number of advisers, by affiliation, for evaluation as of 1 January 1972. (Indicate only those personnel who spend at least some of their time regularly on evaluation work.)
11. Please summarize the types of evaluation activities engaged in by:
    (a) Local agencies outside of the evaluation units, including research institutes and universities;
    (b) International agencies; and
    (c) Individual international advisers.
12. Among local agencies or institutions which ones are fully financed by the family planning funds, and which ones have contractional agreements for specific evaluation or research assignments, from the family planning funds, other government funds, international agencies, foreign universities, etc.?
13. Going back to the evaluation unit (s), please summarize briefly the history of the development of this unit (s) to its present form, noting dates of key events such as organizational changes, standardization of record and report forms and dates of the more important surveys, etc.

H. Service Statistics

1. "Service statistics" refers primarily to information that is generated by programme personnel in the day-to-day execution of their responsibilities. Service statistics for a family planning programme will include such data as number and characteristics of clients, frequency of various types of service provided, programme personnel, records, supply levels, and costs for different phases of the programme. Please note that the term "service statistics" is here used in a much broader sense than "accepter statistics". There may be alternative terminology such as "routine statistics" and "records and reports", used in your country to mean "service statistics". If so, please specify and explain them as used in your country.
2. Please specify, in the organizational chart of the evaluation unit, the personnel who are involved primarily in the collection, processing, tabulation, reporting and analysis of service statistics.
3. Does "service statistics system" as defined by you apply uniformly throughout the country at present? If your country is still in the stage of developing such a system, please summarize below the extent to which it has been established both geographically and hierachically.
4. On what items of information are data generated regarding the accepters? Please list them under the general categories provided below. (If different kinds of data are generated for different sexes or accepters of different methods, please provide the information below, especially for each method or sex).
   Medical history
   Medical examination findings
   Demographic characteristics
   Socio-economic characteristics
   Method accepted
   Previous method (s) used
   Other characteristics
5. In what form are the above data generated (for example, clinic record form, coupon and registers, or more than one of these)? A descriptive statement on how each form is filled out, by whom and when would be useful.
6. Do non-government organizations (such as those run by voluntary organization, industries, etc.) maintain their records in the same way as prescribed for the Government-run clinics or certified doctors?
   Is information available on the same items as in government clinics? If not, which ones are the common items?
7. Are any data generated on such items as:
   (a) Motivational activities such as home visits;
   (b) Other information - education - communication activities (such as group meetings, film shows, pamphlets produced, pamphlets distributed, etc.);
   (c) Personnel (including trained/not trained, in position/not in position, full-time/part-time, salaried or piece rate or both, etc.);
   (d) Equipment and supplies (including contraceptive stock and flow, vehicles authorized and actually in use, etc.);
   (e) Training activities (including training centers, mobile training teams, long and short-term courses of various kinds, number of trainees attending such courses);
   (f) Budget (according to major headings and subheads, please specify);
   (g) Expenditure (according to major heads and subheads, please specify);
   (h) Characteristics of various categories of family planning workers;
   (i) Other items.

   Please give subclassifications under each of the above items. By "data generated" we mean data which could be available at regular intervals if desired from existing records which are normally maintained.

   Some of the above data are generated only at a particular level of administration. For example, data on supervisory staff may be available only at the provincial level. In such cases, please specify these levels.
8. On which items of accepter characteristics, as well as items listed under question 7, are reports sent from the level at which they are generated to the next higher level and so on up to the national level? Please list these for each level. When were reports on these items first regularly sent to higher levels in the country?
9. Please provide formats for the above reports, if possible, with illustrative data, indicating the flow and frequency, from one level to another. If there are deadlines for making such reports, please indicate them.
10. Please mention if some intermediate levels are bypassed for certain reports. Also mention if some reports are sent simultaneously to more than one higher level.
11. What operating procedures exist for sending reports to the highest level of administration or

evaluation expeditiously? (For example, in the Republic of Korea, where coupons are used, copies of the coupon are sent monthly to national headquarters directly from the health centres, while totals of accepters of various methods are also sent in with monthly reports by way of provincial headquarters. Similarly, in India certain reports from the district level are sent simultaneously to state headquarters and to national headquarters.)

12. After the reports are received at the next higher level, are any attempts at feedback to the lower level made (for example, giving comparative performance of the health centers within a district)? If so, please provide illustrative formats.

13. How are service statistics records and reports filed and stored at various levels?

14. What facilities and equipment are normally available to evaluation staff at different levels? Please include calculating machines, data processing machines, computer, typing and duplicating facilities and transportation facilities.

15. Are any tabulations (based on the items of information on which data are generated) other than those which are regularly reported, done at least on a sample basis from clinic cards, coupons, or other records, from time to time? Please give details.

16. Have any attempts at obtaining simple input indices such as number of vehicle-miles, worker-months and unused training capacity of training facilities been made at any level? Please give details.

17. Further, has any attempt to relate output in terms of acceptance to some of the input items been made? Please indicate the types of analyses and the input-output indices utilized.

18. Please provide copies of reports of any kind of cost-effectiveness analyses done in your country based upon information generated through the service statistics system. This may be at provincial or lower levels as well as at the national level.

19. Please describe if any built-in mechanisms in the evaluation system exist to identify or estimate cases of over-reporting of number of accepters or misreporting of characteristics of accepters.

20. Please provide copies of regularly produced reports giving final tabulations based on service statistics (including monthly, quarterly, semi-annual and annual reports).

21. Please provide copies of reports of any analysis done, at central or provincial levels, based upon the above tables and/or using other data.

22. Apart from the normal family planning programme for which the service statistics system may exist, how are special programmes reported upon or evaluated? Do they have a separate service statistics system or are their statistics integrated into the national system? Please describe in detail.
(Special programmes may include activities that are carried out on a limited scale - such as hospital post-partum programme, demonstration projects, experimental clinics or field trials of new contraceptives.)

23. Is there any attempt made to estimate users of non-programme methods such as abortion or programme methods which are also available outside the official programme? (The latter can include privately done sterilization operations, condoms, pills, diaphragms and foam tablets bought from the market) Please describe in detail the procedure for obtaining such statistics or estimates.

24. Are there any official or administrative orders for recording and reporting service statistics in a prescribed manner as regards items of information, format, interval, date of reporting, etc.? If so, please provide a copy.

25. Is all the information collected through the service statistics system actually collected for the specific purpose of reporting?

26. Can you identify some major programme policy decisions which have been taken on the basis of service statistics findings.

27. Are the service statistics reports used for operational purposes at provincial or lower levels to any substantial degree? Which reports? For what purposes?

28. Often the recording (and sometimes reporting) of service statistics at the peripheral (lowest) level is done by persons recruited for other purposes. For example, family planning field-workers may do a lot of statistical work. Is this the case in your country? Please indicate the kinds of workers that are assigned to record the various kinds of data generated at the peripheral level.

ANNEX II

OUTLINE FOR PREPARING COUNTRY REPOTS

Title of the report: Evaluation of Family Planning Programme through Service Statistics, with special reference to (Fiji, Hong Kong, India, Indonesia, Malaysia, Nepal, Philippines, Republic of Korea, Singapore, Sri Lanka, and Thailand, as applicable)

Content: The report shall be an assessment of the existing system of recording and reporting family planning statistics, and the utilization of the statistics for programme evaluation and planning in the country. The format of the report can be flexible. However, the report shall include the following items:

(a) The history of the development of the service statistics system to its present form;

(b) A description of the system at present including format of various records and reports; flow of data; feedback, types of analysis done both regularly and occasionally at different administrative levels of the programme; kinds of information on programme inputs collected, reported and analysed; and extent to which service statistics are used in the analysis of performance and efficiency of workers;

(c) An assessment of the existing system, its advantages and drawbacks and its potential evaluation capabilities — — in the background of the local conditions, i.e., facilities, available staff, etc.;

(d) Suggestions, if any, for an alternative system or modification of the present one that will enable more efficient evaluation of the programme;

(e) Suggestions for collection of additional data on inputs through the service statistics system, and the kinds of analysis that can be done with these data;

(f) A discussion on the feasibility of as well as the need for computerizing the service statistics system in the country assuming computer facilities are available. Consideration may be given to possible areas of utilization of computers not only for evaluation of the programme through service statistics records and reports but also for maintaining a current file of all accepters at the central level. The discussion may also include the change required in the content of records and reports as well as in transmission system appropriate for computerizing the system of service statistics;

(g) A description of the system of indenting for contraceptives and other supplies from clinic level upward and distribution of same from a central level downwards, including use of inventory control procedures, if any;

(h) The desirability as well as feasibility of integrating family planning records with those of MCH or other health services provided by the clinics;

(i) Description of the system, if any, of reporting contraceptive services provided outside the official family planning programme (such as sterilization, IUD insertions or pill prescriptions by private physicians, sales figures of conventional contraceptives or pills from manufacturers or wholesale dealers, etc).

Length: Preferably not more than 40 pages excluding annexes.

ANNEX III

TARGET–SETTING

FIJI

Demographic targets

Crude birth-rate (CBR) of 25 per 1,000 population by 1975 and a "percentage protected" (percentage of women in child-bearing ages protected from pregnancy) of 35.

Determination of acceptance targets

Set by the Secretary of Health. Precise demographic conversions were not attempted but considerations of what was feasible and what was desired led to target decisions.

Targets are also set for administrative divisions.

Any adjustment mechanisms

Flexible with respect to contraceptive method because of the composite "percentage protected" measure.

Comments

Percentage protected: sum of monthly sales of pills (cycles), monthly sales of condoms divided by 10, cumulative total of IUDs *in situ* and cumulative total sterilizations: divided by total number of women 15-44.

HONG KONG

Demographic targets

Maintain CBR at 20 per 1,000 population through 1976, which means an annual recruitment of 30,000–33,000 new accepters.

Determination of acceptance targets

1971-1975 target was set by Research Section as follows:

(i) Estimate the number of births that would give a birth rate of 20 for 1970 and all subsequent years (B_{20});

(ii) Estimate the number of births for 1970 and all subsequent years (B_{67}) had the fertility remained at the 1967 level;

(iii) The difference ($B_{67}-B_{20}$) represents the number of births that should be prevented in 1970 and all subsequent years until 1976;

(iv) Estimate the number of users in each year to maintain the 1967 fertility level for 1970 and all subsequent years (N_{67});

(v) Estimate the number of users required to maintain a 20 birth-rate for 1970 and all subsequent years by the formula

$$N_{20}=N_{67}+(B_{67}-B_{20})R;$$

(vi) Estimate the number of accepters that are required to ensure that there would be N_{20} users for 1970 and all subsequent years taking into consideration the continuation rates of new accepters and the non-programme effects. (The ratio R between users within and outside the programme is estimated to be 2:5.

Any adjustment mechanisms

Special birth-rate studies led to a modification of the 1966 target.

INDIA

Demographic targets

CBR of 32 at end of the fourth five-year plan (1973/74) and a CBR of 30 at end of the fifth plan (1978/79). 1973/74 target was 7,239,170 accepters.

Determination of acceptance targets

The present birth-rate is first estimated. Number of births to be averted is calculated from the desired reduction in birth-rates by a certain year. Number of accepters by each method required to achieve the number of births to be averted is then calculated taking acceptance trends and possible expansion of the services into account. Emphasis is on setting a target of accepters for each contraceptive method. Target are also set for states and districts.

Any adjustment mechanisms

Adjusted annually based on previous years' experiences. Two target-setting committees have been appointed to examine factors for consideration when targets are determined.

INDONESIA

Demographic targets

Not precisely set at the time of reporting.

Determination of acceptance targets

Committee of members from Bureau of Recording and Reporting, Medical Service, Research and Evaluation, and Field-workers set the targets for 1970–1976 by the following procedure:

(i) Estimate the number of women aged 15–49 years;

(ii) Estimate the number of non–sterile married women aged 15–49 years by subtracting first 15 per cent (single) from (i) and then 10 per cent (sterile) from the remainder;

(iii) Apply a "spreading" (see comments) effect of family planning knowledge dissemination to the number derived in (ii). For example, for 1971/72 "spreading" was assumed to affect 30 per cent of the estimated non–sterile married women aged 15–49 years.

Each year the target achievements are reviewed. Past experiences and acceptance trends are figured into the setting of next year's targets. At present there is no emphasis on method–specific targets.

Any adjustment mechanisms

Yes. At one time in 1971/72 accepters exceeded the target, so it was readjusted upwards.

Comments

"Spreading": the dissemination of family planning from urban to rural areas. Higher percentages indicate more dissemination in rural areas.

MALAYSIA

Demographic targets

CBR of 32 by 1975. (Total of 600,000 accepters needed to reach 1975 CBR goal.)

Determination of acceptance targets

Set by evaluation staff of National Family Planning Board. Procedure:

1. Project the "expected" number of births in future years using age-specific fertility rates assumed constant from an earlier year. Corresponding CBRs are derived by applying the fertility rates to the projected number of women in corresponding age groups for each year;

2. "Desired" number of births for future years is calculated from the "desired" CBR each year obtained by assuming a linear decrease in the birth-rates;

3. The number of married women who need to practise family planning to achieve desired reduction in birth-rates is estimated on the basis of the difference between "expected" and "desired" number of births. Then the contraceptive coverage to be provided for the year prior to the one in which births are to be prevented is calculated by using contraceptive continuation rates obtained from earlier surveys.

Any adjustment mechanisms

Targets are reviewed when current data on marital general fertility rate, accepters from programme and non-programme sources, current continuation rates, etc., are available.

Comments

National targets are used as a guide for programme implementation and development. Targets are not assigned to clinics or individual workers.

NEPAL

Demographic targets

No demographic targets have been set. However, for 1970-1975 the target is to offer family planning services to 15 per cent of the married couples (est. 328,000).

Determination of acceptance targets

Set by the Evaluation Section considering past years' performance and numbers of clinics and staff available.

Clinic targets established after examining the achievement per month of each clinic in previous years and taking manpower and facilities into consideration.

Any adjustment mechanisms

At clinic level larger flexibility is available through provision for compensating lower acceptance of one method by higher acceptance of another.

PHILIPPINES

Demographic targets

Reduction of the population growth rate to a level of 2.5 per cent by 1976.

Determination of acceptance targets

Set by the Population Commission. Procedure:

Targets are based on the number of existing clinics and remaining eligible women (The number of eligible women at the beginning of the year minus the cumulative number of accepters will give the number of remaining eligible women). The ratio of remaining eligible women at the beginning of the year multiplied by 45 (optimum average accepters rate per clinic) gives the number of accepters per month per clinic. The product multiplied by the number of clinic-months gives the number of registered accepters during the year. The cumulative number of accepters is adjusted for attrition due to death and sterility by subtracting 4 per cent of the previous year's cumulative figure before adding the current year's figure. The number of clinics to be added annually is based on the density of the population, on the number of existing clinics and the number of remaining eligible women.

Any adjustment mechanisms

Target system is flexible. No method or area breakdown is given, although implementing agencies as well as field-workers have targets.

Comments

Basing the target-setting system on births to be averted is being considered.

REPUBLIC OF KOREA

Demographic targets

Reduction of the population growth rate to 1.5 per cent by 1976.

Determination of acceptance targets

The Minister of Health and Social Affairs with assistance of the Family Planning Section and the Korean Institute of Family Planning sets the target. Consideration of number of eligible couples per area division and past performance enters into target deliberations.

Any adjustment Mechanisms

Targets are reviewed at beginning of year and adjusted according to progress, e.g., increase in sterilizations target in 1972.

Comments

Shift in emphasis towards "permanent" methods of contraception.

SINGAPORE

Demographic targets

Reduction of CBR to 18 by 1975.

Determination of acceptance targets

Members of the Family Planning and Population Board set the target. Factors considered: past five years' fertility patterns, estimated number of eligible women, possible achievement of next 5-10 years, and assumption of present mortality rate prevailing.

Any adjustment mechanisms

Not stated.

SRI LANKA

Demographic targets

A CBR of 25 by 1975.

Determination of acceptance targets

Target CBR of 25 by 1975 requires that 800,000 cumulative new accepters be recruited. By the end of 1968, 100,000 accepters had already been recruited, leaving 115,000 accepters per year as target. Targets are set by a committee appointed by the Assistant Director of MCH Services.

Any adjustment mechanisms

Yearly considerations for revision are recommended depending on:

1. Post–acceptance fertility decline among programme accepters;
2. Use of family planning outside of national programme;
3. Demographic trends:
4. Methods' use–effectiveness; and
5. Subsequent family planning practice of drop-outs.

THAILAND

Demographic targets

A reduction in the growth rate to 2.5 per cent by 1976.

Determination of acceptance targets

Factors taken into consideration: past acceptance of family planning and estimated number of women aged 15-44. Expansion of family planning services also considered. Target levels are established after determining the extent of contraceptive acceptance required in terms of reductions in the birth-rates, number of births desired to be prevented and woman-years of protection necessary.

Any adjustment mechanisms

Adjustments are based on accomplishment of previous year.

Comments

Owing to confidence gained from the programme's accomplishments thus far and an awareness of the possible declining morale of the public health worker regarding the workload, targets were set only for the nation as a whole. However, provincial targets were set unofficially for administrative purposes.

ANNEX IV

DEFINITIONS OF KEY TERMS AND CONCEPTS

The following symbols have been used throughout this Annex except in 1 (a), 1 (g), and 1 (h):

X = country definition in basic agreement with standardized definition

X+ = country definition has specifications additional to standardized definition

X- = country definition has fewer specifications than standardized definition

O = definition not given or term not used

1. SERVICE CONTEXT

(a) Categories of contraceptives

Mechanical: Those that prevent conception by preventing the entry of sperm into the uterus by a barrier, or by preventing implantation of the ovum.

Chemical: Those that prevent conception by destroying the sperm.

Hormonal: The hormonal substances that are taken orally or by injection to prevent ovulation which in turn prevents conception.

Surgical: Method by which the Fallopian tube of the female is cut and sutured to prevent the ovum and sperm meeting in the uterus, or where the spermatic cords of the male are divided to prevent sperm generated in the testicles from travelling up.

Natural: Methods that prevent conception by the nonutilization of any mechanical, chemical or surgical means.

Conventional: Those methods that have been used by people for sometime.

FIJI:

Artificial	Sterilization; IUD, pills and injectables (hormonal); barrier: condom and diaphragm; chemical: foams and pastes
Natural	Rhythm, *coitus interruptus*, abstinence (also termed 'traditional' and 'folk') and lactation

HONG KONG:

Mechanical	Diaphragm, condom, IUD
Hormonal	Injectables and oral pills
Chemical	Foams and jellies
Surgical	Sterilization
Conventional and traditional	Abstinence, withdrawal, rhythm douche

INDIA:

Programme methods	(1) Sterilization, (2) IUD and (3) conventional contraceptives, e.g. condoms, diaphragms, jelly/cream and foam
Non-programme methods	"Natural" methods
	Oral pills available through medical prescription

INDONESIA:

Mechanical	IUD
Hormonal	Pill
Chemical	Vaginal jelly
Simple	Condom, vaginal jelly and foam tablets
	Vasectomy and tubal ligation available from hospitals

MALAYSIA:

Hormonal	Eugynon, ovulen, dougynon and Amenorrone forte (for pregnancy test) and gynavolar; depo-provera (continued after experimental period)
Mechanical	IUD (lippes loop, sizes A-D) and experimentation with Copper-T
Surgical	Tubectomy and vasectomy
Conventional	Condom (Durex, Metro and London)
	Above are national programme methods and brands; other categories of contraceptives are available through the Family Planning Association (FPA).

NEPAL:

Surgical	Vasectomy and tubectomy
Chemical / hormonal	Oral pills and depo-provera
Conventional	Condoms
Traditional	Rhythm
	FP/MCH project provides only pill, loop, vasectomy and condom; depo-provera given to 50 clients on experimental basis.

PHILIPPINES:

Mechanical	Condom, IUD and diaphragm
Chemical	Foams, jellies and suppositories
Hormonal	Pills and injectables
Conventional	Rhythm

REPUBLIC OF KOREA:

Programme	IUD vasectomy, condom and oral pill. Tubal ligation through hospital programmes
Non-programme	All other methods

SINGAPORE:

Mechanical	Diaphragm and condom
Chemical	Jelly and foam
Hormonal	Oral pills and injections
IUD	

SRI LANKA:

Mechanical	Condom and diaphragm
Chemical	Jelly and foam
Hormonal	Oral pills and depo-provera (experimental)
Surgical	Tubectomy and vasectomy
Natural	*Coitus interruptus* and rhythm
Conventional	Condoms, rhythm and *coitus interruptus*
IUD	

THAILAND:

Government-recammended	IUD, pill, tubectomy and vasectomy
Government-recommended but not supported	Hormonal: injection (depo-provera) mechanical: diaphragm and condom chemical: foam and jellies conventional: *coitus interruptus*, rhythm and abstinence

(b) Incentives/disincentives/compensation

Incentives: (a) Adopter incentives: direct payments in cash or kind given to the accepters of family planning
(b) Use-diffuser incentives: direct payments to those who recruit new accepters of family planning on a piece-rate basis.

Disincentives: Measures to discourage one from having many children.

Compensation: Money paid to those who suffered a loss in wages or out-of-pocket expenses in order to receive family planning services, as in case of client, or to disseminate, as in case of motivators.

FIJI: O

HONG KONG: O

INDIA: X+

Compensation money given to accepters and motivators for loss of wages and out-of-pocket expenses. Incentive money given to doctors and paramedical personnel. Amount varies by area and method accepted:

	Vasectomy	*Tubectomy*	*IUD*
Accepters	Rs 10—20.50	Rs 14—30	Rs 2—7
Motivators	Rs 1.50—10	Rs 1.50—10	Rs 1—2
Doctors	Rs 2—10	Rs 1—10	Rs 1—2
Paramedical personnel	Rs 0.25—4	Rs 0.25—7	Rs 0.75—2

INDONESIA: X

Incentives given to family planning field-workers at the field level; also additional payment given to National Family Planning Co-ordinating Board (NFPCB) personnel
Compensation given to clinic personnel to do family planning work at clinic.
No adopters incentives

MALAYSIA: X–

Disincetives: paid maternity leave up to third pregnancy only

Compensaton: some estates compensate vasectomy clients who suffer a loss of wages

NEPAL: X

Medical officers receive US$2 for vasectomy US$.50 for IUD (first insertion)

PHILIPPINES: X–

Salary/incentive system for clinic personnel
Honorarium in pesos -

doctor	70
nurse	50
midwife	50
motivator	130

REPUBLIC OF KOREA: X–

Fees paid to doctors for family planning services rendered
Referral fees to field-worker for recruiting IUD and sterilization accepters and compensation to field-worker for field-work.
No disincentives; no adopter incentives

SINGAPORE: X

Incentive: reward to client only; person accepting post-partum sterilization is not charged *accouchement* fee.
Disincentive regulations since 1973:

1. Further increase in delivery charges in government hospitals with each additional child
2. Reduction of income tax relief from five children as previously to only the first three
3. Reduction of paid maternity leave both in government service and under the Employment Act from three to two confinements
4. Lower priority of allocation of public housing flats to bigger families

SRI LANKA: X

Incentive: system in force in 1968/69 now discontinued but a in few, states other agencies give Rs 5 for IUD insertion to mothers, Rs 5 if retained for one year

THAILAND: O

May try on an experimental basis

(c) Information/education/communication media

These are the various channels through which family planning information is made known to the public.

FIJI: X

Impersonal: radio, press, posters, signs, pamphlets, cartoon strips, films, postal frankings, slides
Personal: home visits, clinic consultations, lectures, group meetings and discussions

HONG KONG: X

Word of mouth among accepters, persuasion from welfare workers, posters, pamphlets, TV or radio, exhibitions, press releases

INDIA: X

INDONESIA: X+

To transfer awareness and knowledge and to motivate through public information, face-to-face group talks
Mass media: radio, TV, newspapers, magazines, films, posters, brochures, billboards, slides, film strips, orientation courses; use of the family planning field workers

MALAYSIA: X+

Information: pamphlets (in several languages), audio-visual material
Education: given by clinic nurses to clients on their first visit, at group meetings
Communication: press reports, TV, radio

NEPAL: X+

Home motivation (follow-up visits), priority couple surveys, community education, radio programming, booklets, posters, newsletters, press releases, cinema, display board

PHILIPPINES: X+

Information motivation: clinic-based as well as non-clinic-based motivators provide the direct motivation; Information, Education and Communication (IEC) mobile teams for indirect motivation
Education: population education for sixth grade and high school students.
Communication: supplementary materials for above efforts.

REPUBLIC OF KOREA: X–

Conducted by health educators and material producers

SINGAPORE: X

Mass media: radio, TV, newspaper, cinema slides, films, posters, pamphlets, booklets. All types of mass media available in the four official languagues
Education and information: post partum contact service, marriage guidance talks, talks to schools, community centres, offices and factories, talks to mothers in MCH clinics and during home visits

SRI LANKA: X+

Information: provided by government employees, doctors, nurses, midwives, advertisements, press, radio

Education: changing behaviour regarding family planning done by doctors, health educators, public health (PH) inspectors, PH midwives

Communication: pamphlets, posters, slides, films, radio, press, mail—outs

THAILAND: X+

Word of mouth communication with media aids, e.g., pamphlets, posters, etc. is used; mass media programme has been launched based on a pilot operation programme including radio and television; mobile health education teams with sophisticated audiovisual equipment are also in use.

(d) Family planning clinics

An establishment where FP services are provided through an authorized medical staff.

FIJI: X+

Specified time, purpose, with medical staff

HONG KONG: X

Consultation and supplies

INDIA: X

Centre: at least one medical officer and one promotional worker, located at a health centre

INDONESIA: X+

Where all contraceptive methods are available; most clinics are integrated with health services.

MALAYSIA: X+

Static clinic (main clinic), full-time, specific staff members, located at a MCH centre or district hospital or in some cases on private premises. Satellite (mobile) clinic, part-time with staff from a static (main) clinic

NEPAL: X

PHILIPPINES: X+

Time, location, staff, parent institution specified and where all contraceptive methods are available

REPUBLIC OF KOREA: X

(Open full-time) used synonymously with health centre

SINGAPORE: X

SIR LANKA: X

With further specifications if clinic is under national family planning programme

THAILAND: X

Elaborates on the operational structure but no further qualifications given

(e)

(e) Health centre:

A centre where health services (including ante-natal, post-natal, and child welfare services) are offered through the national health ministry

FIJI: X+

Urban health centre: confined to Suva. Specific staff with FP clinics held by visiting medical officers.

Rural health centre: health post with routine FP services available at all times except when staff is away in the field (for 8-16 hours per week)

HONG KONG: X

Used synonymously with MCH centres

INDIA: X

INDONESIA: O

MALAYSIA: X

(Main health centre: located in a rural area with a full-time doctor; usually one per health district. Family planning is provided in many of these centres by the staff of the Ministry of Health or Family Plan-ning Board staff

NEPAL: X

PHILIPPINES: X

Operated by the Department of Health (DOH) and provides FP services

REPUBLIC OF KOREA: X

FP services are generally provided through private physicians

SINGAPORE: X+

Known as MCH clinic where FP services are provided in addition

SRI LANKA: X+

Where services are mostly MCH ones. FP clinics can be held. Buildings usually rented rather than owned by the Department of Health

THAILAND: X+

(f) Subcentres:

Provides FP services

A centre which
1. Is under the control of the health centre
2. May distribute contraceptives
3. May engage in promotional activities
4. May follow up cases

FIJI: O

HONG KONG: O

INDIA: X

Has at least one promotional worker; it is hoped to have one per 10,000 population.

INDONESIA: O

MALAYSIA: X+

Located rurally with a doctor visiting on certain days from the main health centre; usually four sub-health centres per health district. Many of these centres are providing FP services.

NEPAL: O

PHILIPPINES: O

REPUBLIC OF KOREA: X–

Often only township administrative offices rather than separate structures; do not have doctors

SINGAPORE: O

SRI LANKA: O

THAILAND: O

(g) Others

FIJI: Divisional and subdivisional centres; same as urban health centres

Nursing posts: rural health post staffed by one PH nurse who holds regular clinics but spends half time home-visiting

Area medical officer: holds a regular weekly clinic

HONG KONG:

Mobile clinic: FP services offered from a van or a boat, location not fixed

Static clinic: FP clinic with fixed location

Mobile team with fixed clinic locations: team of a doctor, nurse and clerk (s) which offers FP services from more than one clinic (because staff is full-time and clinic is part-time). Team moves around to clinics.

Operation theaters: sterilization clients are referred to Government-sponsored hospitals.

INDIA:

Contraceptive distribution centre; person or institution (without a FP centre or subcentre) which is authorized to distribute contraceptives free to all receptive couples

Depot holder: person or organization authorized to distribute contraceptives at normal subsidized price

Mobile unit: self-contained unit with a medical and paramedical staff to carry out sterilizations or IUD insertions and has no fixed locality for operations (similar to Hong Kong's mobile clinic)

Static sterilization unit: special complement of staff is sanctioned for running sterilization services (from a hospital)

Camp: a gathering of persons organized with special efforts to drive home a specific family planning programme

INDONESIA:

Mobile clinic/unit team: group of clinic personnel (doctor, a midwife and a nurse) who go to villages to render family planning services. Villages usually do not have fixed clinics; they use any available vehicle

MALAYSIA:

Midwife-cum-quarters: serves as a station for domiciliary midwifery services in rural areas; usually four to one sub-health centre

NEPAL:

Mobile vasectomy teams: team of one family planning officer, one medical officer, one auxiliary health worker and one office servant who go out to perform vasectomies and provide other contraceptive services

PHILIPPINES: Not specified

REPUBLIC OF KOREA:

Mobile units and Planned Parenthood Federation of Korea demonstrtion clinics: provide IEC; one in every province; four are in Seoul and are *bona fide* clinics

SINGAPORE:

Mobile team with fixed clinic Locations: (same as Hong Kong's)

SRI LANKA:

Not specified

THAILAND:

First-class health centre: where FP services are provided by one doctor, 12 paramedics and midwives, serving an average of 10,000 people

Second-class health centre: two staff members (one sanitarian and one PH nurse or midwife)

Midwifery centre: one midwife

(h) Full-time/part-time clinics

FIJI:

Full-time: 8 a.m.-4.30 p.m., 5 days per week;

HONG KONG:

Full-time: 9 a.m.-5 p.m., part-time: 9 a.m-1 p.m. or 2 p.m.-5 p.m., sometimes extended to 7 p.m. Full-time clinics run 10 1/2 sessions per week, each session lasting 3-4 hours. Part-time clinics run less than 10 1/2 sessions.

INDIA:

Varies with the states

INDONESIA:

Full-time: 8 a.m.-2 p.m., part-time: anything less

MALAYSIA:

Static: 8 a.m.-12.45 p.m.; 2 p.m.-4 p.m. Monday-Friday and 8 am.-12.45 p.m. on Saturdays

Satellite: 1-4 times per month 8 a.m.-12.45 p.m. or 2 p.m.-4 p.m.

NEPAL:

All clinics are full-time ranging from once a fortnight to six days a week, depending on the season as well as the rules and regulations followed by the Department of Health.

PHILIPPINES:

Full-time: 8a.m.-5 p.m. Monday-Friday or 8 a.m.-4.30 p.m. Monday-Friday and 8 a.m-12.30 p.m. on Saturday. Part-time: 20 hours per week.

REPUBLIC OF KOREA:

Not specified

SINGAPORE:

Full-time: 8 a.m.-4.30 p.m. Monday-Friday and 8 a.m.-12.30 p.m. Saturdays. Certain clinics are open up to 7 p.m.; others on Saturday afternoon. Part-time: clinics which are open for FP services on certain hours and certain days of the week.

SRI LANKA:

Full-time: all employees of the Department of Health Services (DHS) are full-time and work 8 hours per day. Part-time: since DHS workers are multipurpose, they are expected to work on FP part-time. Hours: 8 a.m.-5 p.m. FP clinics held in mornings or afternoons as convenient.

THAILAND:

All staff is full-time. Clinics held once or twice a week throughout the health centre system. At regional MCH centres they are held on weekdays.

2. WORKERS

(a) Multipurpose/single-purpose workers

Multipurpose (M): those FP porkers who also regularly work on other health services.

Single-purpose (S): those who work on FP full time.

FIJI: X

Most of FP work handled by M.

HONG KONG: X

S used mostly

INDIA: X

Both M and S

INDONESIA: X

Most NFPCB personnel are S; health personnel at field level working at FP clinic can be considered as M.

MALAYSIA: X

All staff from NFPB and FPA are S. All staff from the Ministry of Health and other agencies are M.

NEPAL: X

All are M because MCH and FP programmes are integrated.

PHILIPPINES: X

Rural health unit personnel are M; only motivators are S. Personnel of other participating institutions are S.

REPUBLIC OF KOREA: X

All workers usually S

SINGAPORE: X

FP Board staff are S; all others are M.

SRI LANKA: X

All workers in National Family Planning Programme (NFPP) are M; workers in FPA are S.

THAILAND: O

Field-workers are S or M depending upon duties; under study now.

(b) Doctors

A doctor is:

1. A registered medical practitioner
2. Employed by either the Department of Health or the national family planning programme
3. Background qualifications include a degree in Western medicine or a licentiate in medicine and surgery.

FIJI: X

Medical officer: full-time salaried staff; graduates of Fiji's School of Medicine (five years) plus one year of compulsory internship; FP medical officer: four officers are women with experience in obstetrics and gynaecology and inservice in obstetrics and gynaecology and in-service family planning training

HONG KONG: X

part-time and paid by sessions; can undertake private or specialist practice. Advisers: unregistered, not qualified to take private practice. Background of five year medical course with certificate. Employed either full or part time and paid salary or by sessions respectively.

INDIA: X

In a primary health centre both first and second medical officers oversee the FP and health programmes.

INDONESIA: X–

Medical doctor trained to provide FP services in clinics; outside the official working hours most doctors have private practices.

MALAYSIA: X

Medical officer: has medical qualification and full registration with Malaysian Medical Council and is trained in FP.

NEPAL: X–

Medical Bachelor and Bachelor of Surgery passed, or equivalent (Intermediate Science passed with six years of study in medicine and surgery.)

PHILIPPINES: X+

Additional qualifications:

- Specialized training in family planning
- Has good moral character
- Interested in rural health work and upholds family planning goals
- Speaks dialect of community to be served

Part–time with either salary or honorarium depending on whether employed by the Institute of Maternal and Child Health (IMCH) or the Department of Health

REPUBLIC OF KOREA: X

Mostly private doctors involved. Report mentions that doctors serve as programme managers at the central and provincial levels of government and as mobile team leaders of mobile clinics.

SINGAPORE: X+

With training in FP.

SRI LANKA: X

Family Planning Association's doctors are part-time and paid according to clinics conducted or work done (not on a piece basis). Assistant medical practitioners or registered medical practitioners who have served more than ten years in charge of rural hospitals. Require: certificate from the Faculty of Medicine and three year course in medicine and surgery. Medical officer: graduate of medicine and surgery who has PH training or degrees or diploma in PH,

THAILAND: X+

Physician and medical officer: has MD degree and is trained in both theoretical and practical aspects of family planning.

Doctors (addenda)

FIJI: X

Graduate of Fiji School of Medicine or overseas recognized institution. Former not allowed private practice. (Out of 250, about 25 in private practice.)

HONG KONG: X

Same definition as in (b).

INDIA: X

Any system of medicine.

INDONESIA: X+

Graduate of Medical Faculty, outside of official (8 a.m.-2 p.m.) practice in hospitals or health centres, most have private practices. Private doctors usually are retired government servants.

MALAYSIA: X

Must be registered with Medical Council; can be qualified locally or overseas.

NEPAL: X+

Full-time in family planning programme and get salary from FP/MCH project; DOH doctors work in health centres or hospitals under DOH; part-time work for FP for a few hours and receive monthly salary from project. Contract doctors are those on contract to project.

PHILIPPINES: X

Chosen by mother institution on basis of administrative requirements

REPUBLIC OF KOREA: X–

Very few public doctors. Family planinng: 2 kinds of doctors: one for loop and one for sterilization. Private doctors receive a service fee from the government.

SINGAPORE: X

Private or government.

SRI LANKA: X

Medical officers: Government-employed. Private-self: employed. Certified doctors: practice medicine after 10 years as assistant medical practitioner in a rural hospital.

THAILAND: X

Government doctors work in private clinics daily after duty time (similar to Indonesia).

(c) Nurses

A nurse is:

1. A graduate of specified training programme
2. Registered with DOH

FIJI: X

Public health nurse: years of nursing school plus 1 year of internship in a hospital; full-time salaried staff. FP nurse: same qualifications as nurse but receives in-service training and a diploma in FP. Health sister: 4 months of training in PH nursing plus proved ability. FP sisters: diploma in FP required plus standard qualifications.

HONG KONG: X

Registered: 3-year course at nurse training school and passed Nursing Board examination.

Unregistered. trained elsewhere; not eligible for registration in Hong Kong; often employed in FP clinics.

INDIA: X+

Lady Health visitor: 2 and one half years of training after highschool; supervises 4 auxilary nurse midwives (ANM) who are responsible for MCH services in their area (40,000 population).

MALAYSIA: X+

Nursing sister/trained nurse: certificate of education and registration and also preferably a midwifery certificate. Assistant nurses: certificate of registration as trained assistant nurse and preferably a midwifery certificate, plus FP training.

NEPAL: X–

PH nurse: tenth class pass plus 4 years of training. Senior PH nurse: same as above plus 5 years of work experience.

PHILIPPINES: X+

Along with graduation, must pass board examination and have special FP training at any recognized training institution of the programme plus the last 3 qualifications listed in (b) for doctor (salaried and full-time under IMCH; part-time honorarium under DOH).

REPUBLIC OF KOREA: X–

Senlor FP nurse: at central and provincial governments. FP workers: nurses or midwives at the health centres.

SINGAPORE: X+

Usually with PH or midwifery certificate and training in FP.

SRI LANKA: X

PH nurse: 1 year of training in obstetrics at large hospital in Sri Lanka and 6 months of training in PH at the Institute of Hygiene. PH nurses are selected for this training after 3 years or more as clinical nurses. Clinical nurse: male or female who has completed 3-year basic nurse course at government school of nursing.

THAILAND: X+

Clinic nurse :assists in clinic dutics. Four years' nursing school plus training in FP.

(d) Midwives

A midwife is an individual who:

1. Has completed midwifery training
2. Functions largely as a basic FP area worker
3. Assists deliveries

FIJI: O

HONG KONG: X

Completed 2-year training course, registered with the Midwives' Board of Hong Kong and only rarely employed by FPA.

INDIA: X–

ANM: 2 years of training in an ANM school, 15-day orientation course in FP at regional training centre after appointment in the programme.

INDONESIA: O

MALAYSIA: X

Experimenting with traditional midwives *(kampong bidans)* as motivators; Government-trained midwives used in integration project and Federal Land Development Authority (FELDA) scheme.

NEPAL: X–

Assistant nurse midwives: eighth class pass plus 2 years of training.

PHILIPPINES: X+

Graduation from recognized school of midwifery, and special FP training, and also has the 3 other requirements (see doctor).

REPUBLIC OF KOREA: O

Also known as F P workers at health centres.

SINGAPORE: X–

Employed by Ministry of Health (MOH) and trained in FP; FP assistants have complete midwifery training, perform F P duties and are employed only by the Family Planning and Population Board (FPPB).

SRI LANKA: X

One year of training in obstetrics at a large hospital and 6 months of training in PH at Institute of Hygiene.

THAILAND: X

One and one half years of midwifery school; assists nurses; does home and clinic deliveries.

(e) Health Inspectors

A health inspector is:

1. An employee of the Department of Health
2. Responsible for public compliance with environmental health regulations

FIJI: X

Not directly related to the FP programme.

HONG KONG: X

Not related to the FP Programme.

INDIA: X

2 health inspectors for every PH centre; trained in sanitary and environmental health programmes.

INDONESIA: X

A graduate of the Health Inspection Academy and is the chief of sanitary and environmental supervision of the provincial health office. (Also known as a health inspector, because of a direct translation from his Indonesian title *Inspectur Kesehatan*, is the chief of the provincial health office. He, however, is usually a medical doctor with an additional degree such as an MPH.)

MALAYSIA: O

NEPAL: O

PHILIPPINES: O

REPUBLIC OF KOREA: O

SINGAPORE: X

Not used in the FP programme.

SRI LANKA: X+

Male sanitarians who have completed the Royal Sanitary Examination after a 1-year's course in PH.

THAILAND: O

(f) Health educators

A health educator is an individual who is:

1. Trained in health education
2. Responsible for disseminating sanitation and general health information, which may include sex education.

FIJI: O

Health education is part of the duties of the area medical officer and the PH officials.

HONG KONG: O

Not related to the FP programme.

INDIA: O

Extension educator: responsible for FP education programme in PHC; a graduate in arts, science or commerce.

INDONESIA: O

No formal staff; duties assumed by PH nurses or other graduates from the Health Inspection Academy.

MALAYSIA: X–

Used as motivators only.

NEPAL: X+

Graduates (secondary) with atleast 1 year of training in health education; responsible for health education, FP motivation and communication.

PHILIPPINES: O

REPUBLIC OF KOREA: O

SINGAPORE: X

A university graduate; also disseminates information.

SRI LANKA: X

Selected from PH inspectors on basis of merit or recruited from university graduates. Trained at Institute of Hygiene and sent abroad for further training.

THAILAND: X+

Has completed training course of Health Education Department of School of Public Health. Responsible for FP motivation and communication.

(g) Family planning field-workers

A family planning field-worker is:

1. A non-medical staff member
2. Responsible for motivation and encourages continuation of FP practice
3. Working in a designated area
4. Working extra-clinically

FIJI: O

No separate category of field-workers. Field-work is carried out by nurses and doctors.

HONG KONG: X

Can refer to doctors, advisers, clinic clerks and welfare workers who offer direct and personal services to the public. Also refers to welfare workers (originally called FP field-workers), who are members of the Social Work Section; non-medical.

INDIA: X–

FP health assistant: peripheral male FP worker with primary responsibility of educating and motivating the male population into accepting FP; non-medical.

INDONESIA: X

Conduct home visits

MALAYSIA: O

No home-visiting policy. FP workers: must have good general education with experience in midwifery or in a recognized branch of social work. Under the Service Division. FP field assistants: must have Certificate of Education, working knowledge of national language and preferably some social work experience. Assistant information officers: provide and carry out IEC activities; education certificate, have language proficiency and 5 years of experience in information media.

NEPAL: X–

FP officers: graduates plus 3 months of training in FP and MCH programme. Auxiliary health workers: tenth class pass plus 2 years of training. Health aides: eighth class pass plus 6 weeks of training in FP and MCH programme (term similar to the Republic of Korea's).

PHILIPPINES: O

(See motivator.)

REPUBLIC OF KOREA: X

Health aides: some have finished 9-month training course; others are not trained. Make home visits, conduct group meetings and distribute pills and condoms.

SINGAPORE: X–

A nurse, midwife or social worker who does home-visiting on certain days. (FP may be only one of the services given during a home visit.)

SRI LANKA: O

THAILAND: X–

Home visitor, FP field-worker, FP worker: duties are as specified but training not mentioned. Distinctions between 3 categories under evaluation now.

(h) Motivators

A motivator's functions are to:

1. Inform and convince potential accepters to practice a particular method of FP
2. Encourage continuation of practice

FIJI: O

HONG KONG: O

Case or welfare workers who identify women in need of FP; salaried. Otherwise, term not used.

INDIA: X+

Employed under the programme. Non-programme employees can also be motivators if they bring individuals to the FP centres.

INDONESIA: X+

Professional: have had training in family planning motivation work; full-time employees; conduct home visits; also known as FP field-workers, who receive incentives for new accepters.

Voluntary: have received FPtraining; talk to groups, give lectures, work independently. Example: Indonesian Planned Parenthood Association (IPPA) has speakers' bureau to coordinate work of voluntary motivators.

Individual field-workers: on own initiative assist the professional motivators.

MALAYSIA: O

Motivational work done by clinical staff.

NEPAL: X+

Paramedicals are the motivators; receive salary and field visit allowances.

PHILIPPINES: X+

At-large motivators: not affiliated with service clinics; refer motivated clients to clinics.

Clinic-based motivators: affiliated with the clinic and part of the staff. In general, should: (1) have time to devote to FP; (2) be at least 20 years old; (3) preferably be married; (4) preferably have children; (5) preferably be a satisfied accepter; (6) have positive attitude towards FP; (7) have an interest in people.

REPUBLIC OF KOREA: O

SINGAPORE: X–

Motivational work is performed by all MCH/FP workers.

SRI LANKA: O

Public health midwives and other paramedical staff are used as motivators.

THAILAND: O

Health educators and other clinic staff are responsible for motivational work.

3. ACCEPTANCE

(a) Eligibility criteria

1. Person must be medically fit for the method selected.
2. Person must be in the reproductive age group.

FIJI: X

Women aged less than 30 years old with fewer than four children are discouraged from tubal ligation except for medical contra-indications.

HONG KONG: X–

Only medical fitness necessary; for sterilization: usually confined to clients over 30 years with 2 or more living children but may be relaxed if necessary; free choice of contraceptives.

INDIA: X+

Couples with 2 or more children are eligible for sterilization.

INDONESIA: X–

Married persons.

MALAYSIA: O

NEPAL: X–

No age limit specified; free choice of methods.

PHILIPPINES: X–

No age limit specified; free choice of approve methods.

REPUBLIC OF KOREA: O

SINGAPORE: X–

No age limit specified.

SRI LANKA: X–

No age limit specified; free choice of methods.

THAILAND: X–

Used to have limit of four or more children before sterilization could be done: no longer apparently; age limit or medical considerations not specified; free choice of methods.

(b) Eligible/target couples

1. Married
2. Ages between 15 and 44

FIJI: X

Married women 15-44 yaars of age.

HONG KONG: X–

All couples exposed to risk of unplanned pregnancy. Target couples: all married women in reproductive age group.

INDIA: X

Married women 15-44 years of age.

NDONESIA: X

Married women 15-49 years of age.

MALAYSIA: X–

Married women 15-49 years of age. for vasectomy patients; there are no official age limits.

NEPAL: X–

Total married fertile women aged 15-44 years. Target couples: 15 per cent of the eligible couples (women aged 15-44 years).

PHILIPPINES: X–

Women: aged 15-44 years.

REPUBLIC OF KOREA : X

Married women 20-44 years of age.

SINGAPORE: X–

Eligible women: those exposed to unplanned pregnancy; target: all married women in the reproductive age group.

SRI LANKA: X–

Married women 15-49 years of age
Target couples: couples to be reached by FP staff to provide FP services.

THAILAND: X

Women 15-44; men 15-59.

(c) Accepters:*

An accepter is an individual who accepts or uses a family planning method to prevent pregnancy.

FIJI: X

New accepter: a person who uses an artificial method of contraception for the first time (including IUD and sterilization); includes only those who switch from a natural to an artificial method.

First attendance: new accepter

Revisit: number of others receiving supplies or medical check-up at clinic or home.

HONG KONG : X+

New accepter: one who registers for the first time in a birth control clinic with the intention of using a contraceptive method.

Old accepter: old case who was previously registered.

User: any person using a method at a given point in time regardless of whether that person has joined the FP programme or not.

Irregular user: a user whose contraceptive practice has been interrupted for various reasons.

*The definition of an accepter in the report of the Expert Group on the Assessment of Acceptance and Fffectiveness of Family Planning Methods, an ESCAP-regional seminar, is more specific: "The taking of service and/or advice from such a Programme, i e. having an IUD insertion or a sterilization operation or receiving supplies (or advice on methods such as 'rhythm' or 'coitus interruptus' with the intent of using the methods)".

INDIA: X–

Is using or had used a method; for service statistics only those using sterilization, IUD or Conventional contraception are considered accepters.

INDONESIA: X

Programme accepters vs. non-programme accepters: depends upon channel of accepting methods (programme or commercial).

New accepters: practice for the first time and also those mothers in post-partum adoption (even if she was an accepter prior to pregnancy).

Old accepters: accepters who continue to receive FP services from clinic.

MALAYSIA: X

Classifies an accepter only once in a lifetime.

Provisional accepter: willingly accepts first supply while being visited at a hospital, home or any place other than a family planning clinic.

Continuing user: accepter who continues using a method.

Active users: accepters who have not missed appointments or are having appointments due in the months following their acceptance or revisits,

Also; used onlyby FPA:

New patients, old patients, revisit attendance, transfer patients: (if patient subsequently visits another clinic, she is defined as an old patient); FPA transfer and NFPB transfer patients are not the same. Latter must be registered accepters.

NEPAL: X

New accepter: accepts contraceptive services for the first time.

Old accepters: all others.

Continuing accepters: if clients come to clinic on appointed date, or not more than one month late.

PHILIPPINES: X

Transferee: accepter of one clinic who registers as a new accepter at another clinic.

REPUBLIC OF KOREA: X

User: regular practice of FP; differentiations by methods (new and continuing). Reinsertion of IUD counted 6 months after first insertion.

SINGAPORE: X+

Registered with Family Planning Board and using one of the methods offered by the Board.

SRI LANKA: X

(Acceptance through programme personnel)
New Accepter: same as others.
Old Accepter: continuation of use.
User: use of a method; similar to old accepter.

THAILAND: X

New accepters: includes those who switch methods.
Old accepters: continued use.

(d) Drop-outs/discontinued users

Those who discontinue use of a family planning programme method for personal or medical reasons.

FIJI: O

HONG KONG: X

Ceased to attend the clinic.
A discontinued user of a method: may or may not be using another method.

INDIA: X

Three reasons specified in definition: discontinue use because of desire for another child, pregnancy or other medical or personal reasons.

INDONESIA: X

MALAYSIA: X

Defaulter or discontinued users: (term used for survey purposes).
Missed appointment: an accepter who fails to return to the clinic for appointment even after 3 months' grace.

NEPAL: X+

Discontinuer: a woman who does not come on her appointment date.

PHILIPPINES: X+

Permanent drop-out: dropped out because no longer capable of pregnancy. Temporary drop-out: an accepter who has stopped the use of a FP method because of pregnancy or other reasons, but can resume the practice of FP.

REPUBLIC OF KOREA: X+

No longer using at time of interview (KAP survey, follow-up survey, etc.) or no longer receiving supplies

SINGAPORE: X–

Defaulter: one who fails to attend for resupply or IUD check-up.

SRI LANKA: X

Also use discontinued user: accepters who discontinue use of mainly IUD or pill.

THAILAND: X

ANNEX V

RECORDS IN USE

Country	Name and format	Contents	Record's movement	Analyses done on contents
FIJI	**Family planning card** Stift, 9 3/8" x 6"	Demographic characteristics and details of first and subsequent visits	Kept at health centre	Has not been analysed on a census or sample basis
	Family record card Stiff, 8" x 5"	Used for women aged 15-44. Provides a complete and continuing record of fertility, child immunization and family planning		
	Daily register	Details of each visit	Kept at health centre	
	Sterilization form	Hospitals, date and type of operation, medical contraindications. Background of client: age, race, number of living children, age of wife (for vasectomy clients), recency of last birth	Sent directly to medical statistician every month. Began use of this form in January 1973.	Anticipate annual tabulations
HONG KONG	**Client case record** 7 1/2" x 10 3/4" NCR sheet. One side holds general client information; the other has the fee and subsequent visit information.	Socio-economic status, (SES) information, obstetrical history, reason and aim of birth control, general pelvic examination, contraceptive accepted, subsequent visit information	Completed by clinic's clerks, then nurses and doctors. Original remains at clinic, a copy is sent to the Evaluation Unit.	New accepters' records sampled 1 : 4 over a year's period by evaluation unit to help to identify types of clients and computation of acceptance rates.
	Daily clinic record	Attendance of new, old and revisiting clients by method is recorded; fee, remarks and referral person.	Sent weekly to evaluation unit where it is summarized and classified.	Compiled into the monthly report. An index of number of attendance per clinic hour is calculated.
	Clinic Referral form	Follow-up information from home visits by welfare workers (For clients who missed their appointments)	Data recorded at clinic and then sent to evaluation unit.	Home-visit statistics are generated from this information.

Country	Name and Format	Contents	Record's movement	Analyses done on contents
INDIA	**IUCD case card**	General client and spouse information, SES background family size, obstetrical and menstrual histories, pelvic examination, previous contraceptive use, facility of IUD insertion, Subsequent observations and services location of service, referral source,	Completed at service locale (simultaneously noted on register). Doctor records examination results and returns card to registration clerk for final action. Cards retained at centres.	Information used for accepter characteristic analyses. Reports convey other relevant information. Recent annual reporting based on analysis of important socio-economic characteristics of accepters of various methods has been introduced.
	Female/male sterilization case cards	General client and spouse information SES background family size, health condition, referral source, location of service, previous contraceptive use, post-operative condition and, subsequent visit information. Also for female: obstetrical and menstrual histories and type of operation	Same as for IUCD card	Information on these cards used in analyses of socio-economic and demographic characteristics of accepters
	Registers Family planning survey Target couple	Permanent registers that are updated from time to time and maintained by the FP health assistants for operational purposes	Retained at service level	Consolidation onto return forms which are then analysed at higher levels
	Other registers: Daily case Conventional contraceptive stock IUCD Sterilization Community education Control Consolidation Conventional contraceptive issue	Maintained to keep a record of a activities of the family welfare planning centres on the basis of which the service statistics are Consolidated and supplied to the higher levels	Most retained at the service unit levels	Data received through various returns are analysed at the district, state and central levels

	Name and format	Contents	Record's movement	Analyses done on contents
INDONESIA	**Referral card** stiff, folded down the centre, 5 1/2" x 8 1/2"	Name of referred clinic, location. Follow-up rates by the field worker on reverse side. Potential accepter's name, etc.	Motivator gives it to potential accepter to take to clinic. Clinic completes card and returns it to the motivator. Fieldworker records data for her own records and can submit the card to the clinic for the incentive fee.	Provides a record system for monitoring success of fieldworker programme. Used for follow-up home visits by fieldworker/motivator
	Patient identity card stiff, 3 1/2" x 5"	Accepter IC number, clinic number, accepter's name, husband's name, address, next appointment date, remarks	Retained by client; facilitates retrieval of clinic card.	
	Patient index card stiff, 3 1/2" x 4 3/4"	Name of client and IC number	Filed alphabetically at clinic. Facilitates retrieval of clinic *when* IC is lost.	none
	Appointment card for follow-up	Client's name and serial number, covers 24 month period	Kept at clinic; filed monthly. First filled out after first clinic attendance.	Trial analysis for continuation measurement
	Clinic card stiff, 8 1/2" x 14" with a flimsy (7 3/4" x 2 1/2") and a carbon. Flimsy attached towards centre of card, records only responses in coded format.	Accepter characteristics, clinical data, referral source, still desire more children, previous contraceptive use, accepter status, medical examination results, subsequent visit information.	Flimsy removed and sent to Bureau of Recording and Reporting bi-monthly. Card completed and filed at clinic where client receives her contraceptives.	Sampled manually 1:10 for semester analysis of accepter characteristics
	Clinic register	Visits of new, old and revisiting cases, their names and IC numbers	Kept daily and consolidated for monthly report	none
	FP clinic registration card	Request for a six digit registration number when clinic is established as an official operating clinic.	NFPCB regency office maintains records	

Country	Name and format	Contents	Record's movement	Analyses done on contents
MALAYSIA	**Facesheet and clinic case card** Face-sheet: 5 3/4" x 8" Stiff card: 5 3/4" x 11 3/4"	Accepter characteristics. pregnancy and menstrual histories, medical examination (pelvic) desire for another child, method serviced, subsequent visit information by method	Clinic card kept at clinic for follow-up use. Facesheet is forwarded to evaluation unit every month.	Face-sheets are analysed and reported in monthly, quarterly and yearly reports in terms of accepter status, method serviced and changes in types of methods practiced
	Provisional accepter's form 8" x 13" (register form)	Registration number name and address, race, age, number of children, want more children, want FP, current method given, appointment date due.	Records information on provisional accepters obtained from maternity ward, health centre, group meetings, etc. Form is submitted monthly to central office with face sheets by the seventh of every month.	Analysed occasionally
	Identity card (IC) number reminder (post card) 3 1/2" x 5"	Name and IC number	Card is given to client who did not bring her IC number with her and/or does not know it, and she sends it in when she returns home and fills in the needed number.	
	Appointment card 3" x 4 3/4", stiff	IC number, name, clinic, appointment dates , times and method	Client card is held at clinic until number is recorded. Given to new accepter upon first clinic visit. Appointment dates recorded. Client brings card each time.	
	Daily clinic record (2 pages)	Page 1: Dates, motivational and informational activities (through ward, health centre, home, group meeting or other outlets), post-natal provisional accepters, new accepters, revisits, cycles of pills sold or given free.	Kept at clinic. Designed for daily use.	Used to complete monthly clinic report. Summed each day.

Country	Name and format	Contents	Record's movement	Analyses done on contents
MALAYSIA (continued)	**Consent to vasectomy form**	Page 2: Stock and sale information on loops, condoms and pills; income from sales (to patients, private practitioners, FPA, estates) and from registration fees. Patient and wife's names and address, age, age at marriage, race, IC number, total number of pregnancies, number of live male children, number of live female children, previous contraception, marital status (living together or contemplating divorce), reason for vasectomy.	Signed in presence of witness by both patient and wife. (Vasectomy patients are reported through the facesheets). Note: 3 characteristics recorded would pertain to the husband; the rest of the facesheet is for the wife. Form is retained at the clinic.	
	Referral form	Details about patient, her complaint (s) and services given at referring clinics. Used by clinical staff to refer a client to an "honorary physician" (doctor/specialist appointed by NFPB) to seek advice before continuing family planning service.	Patient carries form to honorary physician who completes it and sends the bottom part back to the clinic supervisor.	Not reported to the evaluation unit.
	Transfer of patient Form	Clinic use	Handed to patient or sent to other clinic. Clinic case card may be attached.	Distinguishes transfers from new accepters to avoid duplication in reporting.
NEPAL	**Female card** with facesheet. 8" x 11"	Social and demographic background of accepter; also information source, previous FP practice, husband's background, medical history, menstrual history and pelvic exam results, subsequent visit information by method and follow-up,	Facesheets sent to evaluation section through the district office along with monthly reports. Card is retained at clinic. If card is filled for loop, then top half of facesheet is sent to evaluation section while lower half is sent to the fiscal section for processing incentive payment to medical officers.	Facesheets used for preparing the accepter characteristics reports.
	Vasectomy card (used to be male card when condom accepters were registered), 6" x 10"	Information on age, education, occupation, last method used, how client learned about clinic, total number of children, dates of last three deliveries by youngest wife	Similar distribution of facesheet as loop client.	

Country	Name and format	Centents	Record's movement	Analyses done on contents
NEPAL (continued)	**Appointment card** (one side for MCH service, other for FP), 5" x 8"	Registration number of client, date of next appointment, for pill clients, space available for endorsement to purchase pills commercially.	Given to all FP/MCH service recipients	
	Registration books (1 sheet for each service area)		All kept at clinic	Used to prepare monthly clinic reports
	1. Clinic daily	Records daily clinic progress. Aids in preparation of monthly progress report. Staff summarizes information from other books onto this one.		
	2. Pill 3. Vasectomy 4. Loop 5. Condom	Record of clients and nature of method serviced (distribution amount)		
	6. District progress	Records amount of education, information and follow-up activities taking place during report period.		

Country	Name and format	Contents	Record's movement	Analyses done on contents
PHILIPPINES	**Client record form** Flimsy, 6 1/4" x 8 1/2" attached to MCH record 11" x 16 1/4", which is folded in the middle	Profile of accepter, age, number of children, education, residence, FP method preferred, purpose for trying FP, source of information on FP. MCH portion contains lab tests, pelvic exam, maternal and obstetrical histories and information about subsequent visits. Male accepters for any contraceptive method also use the client record form with some modifications. Data on FP method, desire for more children, education and residence are supplied by the husband. However, the wife's data are used for the age and date of last live birth. The items on the most important source of information, previous use of FP, purpose of trying FP and previous attendance at other FP clinics take into consideration the couple's i.e., either the wife or husband's involvement.	Made out for every accepter male or female. Flimsies submitted to National Computer Centre (NCC)* monthly. Record form is retained at the clinic.	Analyses of a 10 percent sample done for monthly evaluation report on clinic/programme performance (all cards with registration numbers ending in 0 are selected).
	Return visit record	Information on the status of returning clients who were selected in the 10 percent sample.	Submitted to NCC monthly.	Evaluation of continuation rates and transfer of methods and reason for change.
	Daily record of FP visits form	Information on clinic visits by new and returning clients. Added up to get total case load for that month of the clinic.		Used to determine the daily clinic caseloads for all clinics during that month.

* Computers processing of family planning data is now done at the Population Commission (POPCOM) office

Country	Name and format	Contents	Record's movement	Analyses done on contents
PHILIPPINES (continued)	**Clinic profile form** (4 copies)	Current information about clinic's personnel positions, training, equip ment capabilities and clinic facilities.	Submitted to POPCOM and parent institution upon establishment of a clinic and at the end of each quarter thereafter. (Not later than 30 days after clinic's activation and thereafter as changes occur.)	Used to evaluate clinic's capability in terms of providing FP service.
	Acceptor log book	Registry of clients who visited the clinic.	Retained at the clinic.	
	Client ID card	Contains name, address and ID number of the Reverse side serves as an appointment record for the client.	Issued to new clients upon enrolment in the programme.	
	Appointment slip 5" x 9 3/4", in duplicate, in two colours	Divided into a stub and slip. Stub contains information on date of issuance, motivator's ID, date of appointment, name and address of prospective client and signature of motivator. Slips contain information on motivator's ID, date of appointment, name and address of designated clinic, name and address of prospective client and signatures of motivator and motivated person. Another portion includes physician's notation on whether motivated person became an accepter or not, client's ID, date of visit and physician's signature.	All original stubs are sent monthly to NCC. Slips of prospective clients who appeared in clinic are made regardless of whether or not they became accepters or not.	Used for evaluating field motivator's performance in terms of effectiveness and quantity of work done.

Country	Name and format	Contents	Record's movement	Analyses done on contents
PHILIPPINES (continued)	**Follow-up slip** 5" x 9 3/4", in duplicate, in two colours	Divided into stub and slip. Stub contains information on motivator's ID, name and address of client to be followed up and signature of motivator. Slip contains name and address of client to be followed up, reason for follow-up, notation on whether or not client agreed to an appointment motivator's ID and signature of motivator and client. Another portion contains information on client ID, notation of physician on whether appointment was made or not, his signature and date.	Duplicate slips are issued to clients who have not kept their scheduled return visits to clinic for check-up or examination. All original stubs are sent to NCC monthly together with the stubs of clients who did not make any further appointments and those who kept their appointments.	Used for evaluating field motivator's performance in follow-up activities.
REPUBLIC OF KOREA	**Family planning coupon** 5" x 8 1/3", in two parts—Form A and Form B	Form A: registration number, contraceptive method, address, age of husband and wife, fertility history, recommendations, Form B: First 3 items same as above plus name of client, name of recommender, medical examination and confirmation, service fees and physician or hospital or clinic recommended to	Form A and part of Form B filled in by recommender. Form A is sent to KIFP data unit. Form B receives local health centre director's approval who recommends an authorized physician. Client takes coupon to clinic, hospital or health centre. After service is given, Form B is returned to district health centre for filing.	Characteristics of accepters of loop and vasectomies from time to time.
	Central file system of FP field-workers	Worker's educational and personal background, work experience (dates, length of service, locale), training experience (dates, type, record of attendance),	Whenever worker's file changes, report is sent from health centre to the provincial office. Provincial office forwards change notice to KIFP which reports changes in the quarterly summary report to the Ministry of Health and Social Affairs (MHSA).	

Country	Name and format	Contents	Record's movement	Analyses done on contents
SINGAPORE	**FP clinic card** (folder form with three inserts—IUD, pill and other contraceptives—for recording services rendered by method), 8 3/4" x 11 3/4"	**Front:** SES characteristics, obstetrical history, motivation to accept contraceptives, and record of contraceptive practice at clinic. **2nd page:** clinical exam and lab tests. **3rd page:** additional clinical notes. **Back:** summary record of each visit. **Insets:** record of charges and contraceptives distributed (prescribed), record of reason for attendance, clinical notes, etc.	Completed by nurse; double checked after examination. Data extracted for processing from front and back pages. Front page is read through a microfilm reader; back page is done manually.	Basis of monthly, quarterly and annual tabulations.
	Clinic index card		Filed in alphabetical cross-index at clinic.	
	Out-patient card	Date of next appointment		
	Appointment book		Serves as basis for follow-up if appointment not kept.	
	Application for termination of pregnancy (folder form), 8 1/4" x 11 3/4" with an inset for operation	**Front page:** social, economic and demographic characteristics, family planning and obstetrical history). **Back page:** consent, medical certification of pregnancy, Board approval (Termination of Pregnancy Authorization Board).	Completed by nurse; certified by doctor for pregnancy; sent to Board for approval; inset is sent to hospital. After operation, inset is sent back to Board which then sends the card to the evaluation unit.	Quarterly tabulation of client characteristics and reason for sterilization or abortion.
	Application for treatment for sexual sterilization (folder form), 8 1/4" x 11 3/4" with an inset for operation	**Front:** same as above plus reason for sterilization. **Back:** consent, consent of spouse, Board approval.	Same as above.	Same as above

Country	Name and format	Contents	Record's movement	Analyses done on contents
SINGAPORE (continued)	**Daily clinic register**	Name of clinic; date of visit by type of method serviced (new or revisit client); amount collected; total number of home sales and total number of lady medical officer cases.	Sent weekly to evaluation unit.	Compiled onto weekly and monthly report. A workload index is calculated.
	Post-partum contact form	Primarily an MCH record but collects patient's name, address, registration number, race, age, parity, and other SES characteristics; last pregnancy; recent contraceptive method; previous interview and date; date of clinic appointment and date attended; number and dates of home visits; and result, reason for refusal or method chosen.	Two copies sent—one to evaluation unit, one to clinic. After the woman attends the clinic, the evaluation unit is notified by the clinic.	Not tabulated routinely; detailed analysis done on an *ad hoc* basis (usually annually).

Country	Name and format	Contents	Record's movement	Analyses done on contents
SRI LANKA	**Clinic card** 5" x 8 1/2", stiff	ID number, names and addresses of wife and husband, race, number of living children, date of birth of last child, last menstruation period and date of loop insertion. Space for revisit information.	Filled in by paramedicals.	
	Field card 5" x 6 1/2", stiff	Filled in by PH nurses, midwives or PH inspectors. Contents same as clinic card plus religion of both husband and wife, date of reference to medical officer, follow-up visits for loop clients.		
	Mother's record card 6 1/4" x 10 1/2", stiff folder form	Background information on mother, blood test, last menstruation period, birth details, antenatal record, also details of further visits.	Completed by midwives on home visits and at clinic when mothers visit. Filed for five years.	
	Mother's appointment card 12 1/2" x 5", stiff, printed in four sections	Name, address, registration number, dates of appointment; antenatal record, details of delivery, additional foods issued. Reverse side for "other facts".	Taken to clinic or hospital when mother attends, given by visiting midwife.	
	Daily register	Details of visits.	Kept at service outlets; optional for field units.	Analyses done on returns rather than relying on the registers.
THAILAND	**Accepter log book** 8 1/2" x 13 1/4", mimeographed	Records accepter events: new/old clients, IUD service details, pill, sterilization, other (including condoms) services, pregnancies.	Remains in clinic or other service unit. Completed for a one-month period.	Designed to help in preparing daily and monthly activity reports.

Country	Name and format	Contents	Record's movement	Analyses done on contents
THAILAND (continued)	**Client record form** Stiff, 8 1/2" x 10 1/2", flimsy attached 8 1/2" x 4 1/4"	SES, demographic characteristics of client, client status, FP use history, method chosen, medical history, checklist for pill clients, IUD insertion information, last menstruation period and pelvic exam. Reverse side: subsequent visit information.	Flimsies sent to evaluation unit monthly either directly or through district health office. Card remains at service unit.	Flimsies used for preparing monthly accepter report. Sampled 1 : 60 by evaluation section.
	Accepter card stiff, 3 1/2" x 2 1/2" (2 sides)	Accepter's ID number, name, address and place of issue. Reverse side notes all scheduled appointments.	Card retained by accepter and brought along at each visit to service unit.	
	Follow-up (tickler file) card Two sides, stiff, 6" x 4 1/2"	Contains information on next scheduled appointment, accepter ID number, family planning service details and service unit. Reverse side is continuation of the first.	Prepared by staff for each accepter. When client misses appointment, follow-up action is initiated. Filed as monthly index at service unit.	
	Daily activity report	New accepters by method; Revisits by method; home visits by reason (e.g., post-partum, accepter); cycles of pills distributed to new/old accepters. Above tallies are maintained daily and totalled at the end of each month.	Service units without doctors send their copies to the district health offices. Other service units retain their copies.	

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ANNEX VI

INDENT AND SUPPLY SYSTEMS

Country	How often and who allocates supply amounts	Forms involved, deadlines	How order is executed, delivery system	Period lapse between request and delivery	Verification of receipt	Reserves	Remarks
FIJI	Area medical officer submits request to government pharmacist	Only stock books	Sent via ordinary mail system	Within 2 days of receipt	Government pharmacist keeps a record of issues to each centre	Medical officer responsible for maintaining adequate stocks	Commercial sales account for approximately one third of contraceptive distribution
HONG KONG	Approval of medical Director is necessary. Clinic supervisors responsible for ordering supplies from foreign and local contraceptive distributing agents. Individual clinics notify clinic supervisors of their needs.	Contraceptive stock balances recorded on stock return form and submitted to clinic supervisor daily by clinics. Nurse estimates weekly demand for contraceptive type, fills in requisition form and submits it to the clinic supervisor weekly.	Clinic supervisors maintain records of stock at all clinics and replenish their supplies when necessary. Delivery by Association's vans.			Stocks kept at a level to last 2-3 months in cold storage. Clinics only keep a 2-week supply.	
INDIA	Primary health centres and urban centres prepare indents quarterly. Sent to district FP offices, where requests are consolidated and sent to state FP offices. State FP office sends indent to supply depots after scrutiny.	Indents must reach supply depot by the 15th of each commencing quarter. One copy sent to department of FP.		Within a month if no problem	State FP office, district FP office and centre's medical officer keep a register of quarterly verification and indents, State FP office verifies stock on hand regularly and occasionally makes surprise checks at 10 per cent of the subcentres/PHCs and 10 per cent of the district head-quarters.		State-level staff: Inspection officer of stores and packers

Country	How often and who allocates supply amounts	Forms involved, deadlines	How order is executed, delivery system	Period lapse between request and delivery	Verification of receipt	Reserves	Remarks
INDIA (continued)		Different months allotted to different states for indenting. Urgent requests possible. Forms for request and certificates of verification of receipt used			The district FP office also has surprise physical verification at 50 per cent, PHC /s subcentres. Medical officers must certify verification at all centres has been done on 1st day of previous quarter.		
INDONESIA	NFPCB determines amounts at national level first; done annually when budget is under preparation. Implementing units allocate supplies for own clinics, but distribution is usually direct to clinics from NFPCB warehouses rather than through the implementing unit offices, except for the Armed Forces clinics.	Clinic supply form: 5 copies are sent in monthly to show status of supplies and amounts used. Salary for motivator, health staff and others also recorded as money is received. Sent to regency, province, NFPCB not later than 5th of month following. Warehouse supply report shows contraceptive supplies received, distributed and the balance. Sent from regency warehouse to central and provincial NFPCB. Same form with different code number for provincial warehouse, to be sent to central NFPCB.	Ministry of Health depot (handling unit) transmits 90 per cent to NFPCB provincial handling unit. They in turn transmit 50 per cent of their total stock to the regency warehouses. Supplies are sent every 2-3 months to clinics. Distribution by land by contracted private transporting companies.			2-years reserve at national level; 8-12 months at provincial level; 6 months at regency and 3 months at clinic	A non-request management system. Reserves can be depleted quickly because of high acceptance levels. Regency warehouses can exchange supplies with each other.

	How often and Who allocates Supply Amounts	Forms involved, deadlines	How order is executed, delivery system	Period lapse between request and delivery	Verification of receipt	Reserves	Remarks
MALAYSIA	Doctor/nurse-in-charge determine the amounts allowing for reserves to meet fluctuating demands. Requests sent to Supply Division at NFPB Headquarters. Requests for equipment done as required using same indenting procedures as for contraceptive; but with a separate indent form.	Indent form: 4 copies - store, finance, indentor's and reference copies. Indentors submit first 3 and keep last one.	Distributed monthly by Supply Division. Clinics' staff-in-charge allowed to sell supplies to private doctors and estate clinics.	Depends on the distance but a maximum of one week (sometimes order is transmitted by telephone).	Finance and Indentor's copies returned to indentors for signature upon receipt of supplies. Finance copy then sent to Supply Division after verification.	Larger clinics required to keep 2-month reserves. In general, reserves should not fall below one month's supply, must be carefully stored.	For FPA, integration, FELDA clinics, system is similar with slightly modified forms. Private doctors and estate clinics use indent form or write to Supply Division.
NEPAL	District offices send supply reports to Central Supply Section.	Supply reports sent quarterly. Reports show amount of drugs distributed, received during quarter and balance at end of quarter. 3 copies: district office, supply section and regional distributor.	Supplies sent from Central Supply Section to regional or district offices and from there to the clinics.	Time varies depending on the facilities available.	At every level	Regional and district offices keep some reserves.	Clinics do not have to maintain supply records but must maintain drug expenditure record.

Country	How often and Who allocates Supply Amounts	Forms involved, deadlines	How order is executed, delivery system	Period lapse between request and delivery	Verification of receipt	Reserves	Remarks
PHILIPPINES	FP clinics send monthly report to National Computer Centre * (NCC). NCC prepares packing and shipping lists which are forwarded to POPCOM for approval with a copy furnished to the mother institution.	Monthly clinic summary report, packing and shipping list: Packing-4 copies – NCC – Clinic – RDP – PCW Shipping-3 copies – NCC – RDP – PCW Quarterly distribution	Clinics are assigned to regional distribution points (RDPs) under POPCOM Central Warehouse (PCW). PCW, upon filling requests, ships/transmits materials to RDPs. For remote clinics packages are distributed by RDP.		RDP verifies contents and distributes to clinic representatives. Supplies received also reflected in clinics' monthly reports.	Reserve stock maintained at RDP s.	Stock shipped to clinics sufficient for 3 months consumption.
REPUBLIC OF KOREA	Central government allocates to local centres through city/provincial governments. Amounts are based on targets and most of the distribution occurs at the beginning of the year.	Inventory control	Materials pass downwards 3 government levels to local targets			When difficulties occur, reserves can be transferred from province to province. There is a little reserve at provincial and central levels.	Amounts known because of predetermined targets
SINGAPORE	Every clinic files a stock return to the central office.	Stock return submitted monthly. Issue voucher submitted when new supplies are needed. Copies go to accountant.	Storekeeper at central office verifies stock return to see what amounts were issued. When new supplies requested, sister-in-charge checks clinic's stock returns before issuing more. Clinic sister maintains a record of stocks. Delivery made by Board van.	Within one week	Verification by both issuer and receiver.	Stock kept in clinic should last at least one month	

* NCC functions have now been taken over by POPCOM

Country	How often and who allocates supply amounts	Forms involved, deadlines	How order is executed, delivery system	Period lapse between request and delivery	Verification of receipt	Reserves	Remarks
SRI LANKA	Medical officer at family health bureau approves requisition from clinic. Only the Medical Officer of health or medical officers in charge of clinics can make requisitions.	health supplementary requisition form: two copies, one for clinic and one for MCH Assistant Director Monthly stock return: Sent by medical officer to divisional heads and later to FH Bureau to check on stocks	FH Bureau Supply Center fills requisition and dispatches supply by post (if package is small) or rail (if package is large)	About one month	Medical officer signs invoice and returns to FH Bureau within 3days. Notation is made in stock books.	Sufficient to supply the field staff.	
THAILAND	Service unit's staff prepare form. All sheets are consolidated at district health office onto a new sheet and sent to the provincial medical and health service's office (PMHSO). Centres with doctors can forward form directly to PMHSO. PMHSO consolidates requests again onto one sheet and forwards to central logistics unit.	Supply order sheet: 8 1/2" x 13 1/4" to be sent by person in charge of service unit on a monthly basis. Pill and IUD inventory: Sent along with Supply order sheet. Supply log book: Records supplies on hand, received and issued, the recipients and balance thereafter each month.	Logistics unit. officer determines from order sheet and inventory forms how urgent the request is. Supplies are delivered to PMHSO which serves as the local supply depot office. Service unit staff pick up supplies from district health office or PMHSO, whichever is appropriate.	Depends upon distance and facilities available	Receipts and issues exists for internal checking. Supply log book also notes any supply transactions.		

ANNEX VII

REGULAR REPORTING OF NON-PROGRAMME DISTRIBUTION OF CONTRACEPTIVES

Notes: PS = Private sector, e.g., private medical practitioners, hospitals
CS = Commercial sector, e.g., wholesale companies
VA = Voluntary agencies

FIJI	PS Insignificant CS - Government pharmacist provides two brands of pills to wholesalers for commercial distribution to pharmacists. Pharmacists must maintain a sales register. Non-subsidized pill sales are numerically insignificant. VA - Subsidized condom commercial distribution (by Family Planning Association). Wholesale figures are available, but sales figures by area are inadequate. Non-subsidized condom distribution annual figures are available from the companies.
HONG KONG	PS - Not yet collected, but do have monthly return on number of male and female sterilizations performed by hospitals and clinics. VA, CS, PS - No way of assessing unless a KAP survey is done. Then the estimated total users (from KAP) is reduced by the known number of programme users to get the non-programme users. Using continuation rates, the number of non-programme users can be estimated for years between KAP surveys.
INDIA	PS - Statistics on abortion collected in a special section of Department of Health. CS - Only Nirodh programme has commercial distribution channels (six major companies). All other contraceptive supplies are government controlled. Nirodh programme sends a monthly report to the Evaluation Section.
INDONESIA	PS - Separate reporting system for post-partum programme. Monthly hospital report forms are sent to NFPCB. Quarterly feedback reports are produced. CS - Informal contacts with pharmaceutical distributors. Data collection was attempted earlier for a cost-effectiveness study. Pills mostly provided through the programme. Condom demand is increasing, so reporting may be implemented.
MALAYSIA	CS - *National Co-operation Report on Contraceptive Distribution* sent to large wholesale companies and dealers for obtaining annual distribution figures of methods. At present trying to get figures on contraceptive imports (of pills, and condoms and other conventional contraceptives). VA - Contraceptive services of non-participating agencies not reported.
NEPAL	PS - Not reported: actual number estimated to be small. Abortion information is incomplete. CS - Sales are reported, but not necessarily complete. VA - Family Planning Association reports integrated with programme reports for national achievement report. Depo-provera and post-partum programmes report separately to central evaluation unit.
PHILIPPINES	32 agencies participate in POPCOM logistics system, covering contraceptives and report forms. Otherwise not collected. Logistics system monitors manufacturing and supplies of goods used in the programme.

REPUBLIC OF KOREA	PS - Surveys on induced abortion have been done. Also private pill users were picked up in 1971 survey. MHSA collected data on imports and exports and production of pills and condoms in earlier years. Discrepancies in the statistics exist. Special reports from KIFP cover the hospital programme, which is separate from the national programme proper. VA - None, but PPFK has its own supply and service reporting system.
SINGAPORE	PS - Sterilization and legalized abortion data for the whole of Singapore are available since the law requires that they be reported to the Ministry of Health. For family planning no attempt has been made to record systematically private doctors' services. CS - No sales figures for conventional contraceptives and pills, but depo-provera sales are known. It is likely that wholesale dealers will be asked to supply sales figures in the future.
SRI LANKA	No system yet since non-programme services are negligible. Will be evaluated if need occurs.
THAILAND	CS - 1969-1970 commercial sales figures of pills were collected from drugstores and pharmaceutical companies. The present estimate is that 4 million cycles are sold commercially each year.

ANNEX VIII
CLIENT RECORD CARD

V = Available on the client record card
X = Regularly reported to evaluation on flimsy or copy of record card

CLIENT RECORD CARD	FIJI	HONG KONG	INDIA		INDONESIA	MALAYSIA	NEPAL	PHILIPPINES	REPUBLIC OF KOREA	SINGAPORE	SRI LANKA	THAILAND
			IUD card	Sterilization card								
Accepter characteristics	Female card and family planning card						Card used for pill, IUD and vasectomy clients only		Coupon			
Race	V					X				V	Both spouses V	
Education		X	Both spouses V		Both spouses X		Both spouses X	X	Both spouses X	V		Both spouses X
Occupation		Both spouses X			Husband's X	Husband's X	Husband's X			V		Both spouses X
Income		X				Husband's X				Combined V		
Religion		X		V	X						V	
Area of residence	V	X		V	V	X	X	Wife's or Husband's X	X	V		X
Others										Citizenship data		
Age	V	X	Both spouses V		X	X	Both spouses X	Wife's X	Both spouses X	Date of birth V	Both spouses V	V
Duration of marriage		X				X				V		
Number of live births	V	X		V	X	X			X	V		
Number of sons	(Living) V	X		V	X	(Living) X	(Living) X	(Living) X	X	V		
Number of daughters	(Living) V	X		V	X	(Living) X	(Living) X	(Living) X	X			X
Number of living children				V				X	X	V	V	
Number of children born alive but died since	V				X	X	X	X				
Age of youngest child	V					X					V	
Others	information on child health					Age at marriage			Date of birth			

– Socio-economic status –

– Demographic –

	CLIENT RECORD CARD	FIJI	HONG KONG	INDIA		INDONESIA	MALAYSIA	NEPAL	PHILIPPINES	REPUBLIC OF KOREA	SINGAPORE	SRI LANKA	THAILAND
– Obstetric history –	Date of last delivery	V	X	Interval since last delivery		X	Last three births X	Last three births X	V		V	V	
	Mode of last delivery	V	X						V				
	Outcome of last pregnancy										V		
	Number of abortions, still births	V					X		V	X	V		
	Number of caesareans		X						V				
	Number of miscarriages	V	X				X		V				
	Lactation						X				X		
	Number of pregnancies		X	V	V								
– Menstrual history –	Age at onset of menstruation		X								V		
	Regularity of menstruation		X	V		V	X	X	V		V		V
	Amount of loss of blood	V)	X	V	V	V	X	X	V		V		V
	Pain	V) for IUD accepters only		V	V		X		V		V		
	Cycle length (or LMP)	V)		V	V	LMP	X	LMP	V		V	LMP	LMP-IUD only
	Spotting	V)				V	X	X					
	Past medical and surgical history of significance		X				X	X	V				
– Medical examination findings –	Medical examination findings (a) General examination												
	Body weight		X			V	X		V		V		
	Blood pressure		X		V	V	V				V		V
	Thyroid		X								V		
	Breasts		X			V	V	X			V		V
	Heart		X				V				V		
	Varicose veins		X			V	V				V		V

— Medical examination findings — (continued)

CLIENT RECORD CARD	FIJI	HONG KONG	INDIA		INDONESIA	MALAYSIA	NEPAL	PHILIPPINES	REPUBLIC OF KOREA	SINGAPORE	SRI LANKA	THAILAND
Others					Yellow skin, or eyes, chest, tiredness, shortness of breath, headaches		Epilepsy, jaundice, headaches, foot-swelling, shortness of breath			Abdomen		Jaundice, foot-swelling, chest, shortness of breath, headaches
(b) Pelvic examination							X					
Position of uterus		X	V		V	X		V		V		V
Size of uterus		X	V		V	X		V		V		V
Shape of uterus		X	V		V			V				
Cervix		X	V		V	X		V		V		V
Adnexa		X	V		V	X		V		V		V
Vagina			V			X						Discharge (IUD only)
Pregnant or not			V			X		V				
Hormone contraindications						V		V				
IUD contra-indications						V		V				
(c) Cytological findings												
Pap smear		X				X		V		V		
Pregnancy test						V				V		
(d) Laboratory investigations												
Urine				V	V	V				V		V
Hemoglobin				V						V		
Method accepted:												
Type	V	X		Operation type	X	X	X	X	X	V	V	X
Date	V	X	V	V	X	X	X	X	X	V	V	X
Quantities/size	V	X	V			X	X			V	V	V

—Contraceptive background—

CLIENT RECORD CARD	FIJI	HONG KONG	INDIA		INDONESIA	MALAYSIA	NEPAL	PHILIPPINES	REPUBLIC OF KOREA	SINGAPORE	SRI LANKA	THAILAND
Reason for use of BC		X										
Aim o BC		X						X		V		
Whether spouse agrees		X										
Sources of motivation		X			X	X	X	X	V			
Ever practiced FP						X				V		X
Ever been a FP clinic patient						X		X			V	
Previous method used	V	X	V	V	X	X	X	X		V		X
How long ago started use	V	X								V		
Last method used		X					X	X		V		
Reason for discontinuation						When stopped				V		
Still desire more children					X	X	X	X				X
Subsequent observations services	V	V	V	V	V	V	V	V		V	V	V
Date	V	V	V	V	V	V	V	V		V	V	
Complications	V	V	V	V	LMP	V	V	V				V
Complaints			V	V	V		V			V		
For IUD:												
Discharge	V		V							V		
Pain	V		V			V				V		
Expulsion	V		V			V				V	V	
Others						Many additional details for IUD treatment						
Clinic: fees paid	V	X				V			V	V		
Can client be followed up		X										
Type of client (new transfer)					X					V	V	X
Medical exam confirmation (doctor's signature)		X	V	V	V	X	X	V	V	V		V

ANNEX IX

REPORTS IN USE

Country	Name	Who produces? How often? From what?	Contents	Flow
FIJI	**Consolidated monthly report**	Monthly, by area medical officer; compiled from daily registers and client cards	Population and vital statistics by race (e.g., estimated number of women 15-44 in PH area) FP information (e.g., caseloads, "percentage protected", contraceptive services rendered) Medical information (MCH and PH services rendered)	Sent to subdivisional medical officer by the tenth, divisional officer by twentieth and statistical unit by end of month.
	Quarterly summaries	Quarterly, by medical statistical unit from consolidated monthly reports	National, divisional, subdivisional and area estimates of "percentage protected"; national estimates of women "protected" by method; and geographic breakdown of birth and death rates	Sent to all area medical officers
	Consolidated return	Annual report prepared by the Secretary of Health from all the consolidated monthly reports	* National, divisional, subdivisional and area estimates of "percentage protected"; cumulative figures at end of year; birth-rates by race and divisions; summary of births and ante-natal visits in year, by division and for whole dominion; FP by methods and race; infant and toddler mortality rates	Sent to all divisional, subdivisional and area medical officers, all medical superintendents and all health sisters
HONG KONG	**Monthly report**	Monthly, by evaluation unit from daily clinic records	New/old cases, revisits, total attendance Contraceptive services rendered New cases since beginning of year, since two years ago, average attendance per hour. Above examined by clinic locations, clients' sexes, married life information, sub-fertility totals. Compared with previous operational periods. Also: total number of clinics, total number of sessions and distribution on source of referrals.	Reported to administrative level

*Has accompanying write-up/interpretations.

Country	Name	Who produces? How often? From what?	Contents	Flow
HONG KONG (continued)	**New patients by clinics by method used per month**	Monthly by evaluation unit from daily clinic records	Oral pill, IUD, injection, others; new and initial clients; sterilization applicants; total new patients by clinics	Circulated to all clinics
	Reason for not returning to the clinic	Every two months by evaluation unit. Source of data is clinic referral form filled out by clinic staff for field-workers to visit clients missing their appointments	Frequency distribution of listed reasons and causes	Sent to administrative level, usually Medical Director for information and/or action
	Complication of IUD	Monthly tabulation by evaluation unit based on reports from clinics	Complication by type of loop, present age, parity and time since insertion and total. Total new insertions, total reinsertions and number using IUD	Submitted to the Medical Director
	Monthly summary of welfare workers' records	Monthly by field-work section from welfare workers' daily records	Performance of individual worker: Number of contacts made, slips issued by localities, by settings (e.g., maternity ward), number of working sessions and travelling hours spent in each type of activity	Sent to administrative level
	Semi-annual statistics on recruitment by individual welfare workers	Semi-annually prepared by field-work section based on individual workers' monthly reports (input data) and slips returned through clinic (referral slips)	Code number of workers and her number of working sessions, number of slips issued, number slips returned, number slips issued per working session, number slips returned per working session, number slips returned per 100 issued. Workers are ranked from highest number issued to lowest; average is calculated.	Sent to administrative level

Country	Name	Who produces? How often? From what?	Contents	Flow
HONG KONG (continued)	**11 cross-tabulations**	Compiled quarterly by evaluation unit? Based on client case records	1. Method accepted by age, number of live children; husband's occupation; wife's education; limiting/spacing reasons 2. Number of live children by open interval according to wife's education; husband's occupation, family income; age 3. Previous contraceptives used 4. Methods used by current cases	Sent to administrative level
	Annual report	Published annually by FPA	*Overview of all sections' activities, general statistics and charts	
INDIA	**Forms P_1, P_2 and P_3**	Monthly, by primary reporting units — P_3 is reported by hospitals, conventional contraceptive centres. Information is based on registers and client records	P_1: Information on sterilizations and IUD insertions occuring at centres, camps, mobile units, etc. P_2: Information on the distribution of conventional contraceptives at centres, depot holders, from private medical practitioners P_3: Reports all of the above combined for the peripheral units	P_1 and P_2 are sent to the district FP bureau after smaller subunits' reports have been tabulated (by the tenth); P_3 is reported to the subcentre by the third by rural units; while urban units report to Family Welfare Planning (FWP) Centre by the sixth
	Form E	Monthly by subcentres and primary health centres. Based on community education register.	Community education activities: number of films, dramas, meetings, etc., held during month in rural and urban areas. Cumulative figures for year also.	To reach district FP bureau by the tenth

*Has accompanying write-up/interpretations.

Country	Name	Who produces? How often? From what?	Contents	Flow
INDIA (continued)	**Form T_1 and T_2**	Monthly, by state training centres based on their records	T_1: Regular/special training courses. Category of service personnel by number of new courses held, number of new admissions, number undergoing training at end of month, number trained to date since inception. T_2: Orientation training record. Same format as T_1 except differentiation in terms of full or part-time employment in FP.	Sent to state family planning bureau by the fifteenth with copies to regional directors and Family Planning Commissioner.
	Form S (in 2 parts)	Part 1 is monthly; Part 2 is quarterly by public health centres and FWP centres based on information obtained from stock registers and acquittance rolls.	Part 1. For staff designation of post by number of posts required/sanctioned/in position/of those in position, number trained in FP. Part 2. Equipment and transport. Item desription by number required/sanctioned/obtained/in working order.	Sent to respective city family planning bureau by the eighth or District Family Planning Bureau by the tenth
	Quarterly and annual report on accepter characteristics	One—way distributions collected on 3—4 characteristics; done quarterly and annually on a special form.	Age group, number of living children, total population, number of accepters by method by clinic.	Sent to state family planning bureau by district offices.
	Consolidation register	District level consolidates returns onto this register monthly.	Name of reporting unit and services provided by month. One sheet used for each separate method/service/activity.	Sent to state level.
	Monthly progress report	Monthly report from Evaluation and Intelligence Section of Department of Family Planning based on monthly returns.	*Statements on progress of sterilization (vasectomy/tubectomy) programmes, IUD, distribution of conventional contraceptive programmes; progress of total number of accepters by method, number of couples protected currently, state-wise achievements in terms of targets, and progress in terms of rate per 1,000 population. Also shows number of family planning centres sanctioned and in position in the various states.	Sent to state level and other concerned official agencies along with important points brought out by the monthly review, which are required to be brought to the notice of the state family planning departments. Many states have introduced similar monthly progress reports for use by districts within their state.

* Has accompanying write-up/interpretations.

Country	Name	Who produces? How often? From what?	Contents	Flow
INDIA (continued)	**Progress of Family Planning Programme in India**	Annual progress report from the Department of Family Planning	*– Organization of the programme – Performance, e.g. number of sterilizations (total and per 1,000 population), number of IUD insertions (total and per 1,000 population), equivalent conventional contraceptive users – Nirodh marketing programme – Post-partum programme – Organized sector programme – Voluntary organizations – Training – Research – Motivation–mass and extension education – Expenditure	Open distribution
	Programme Information	Annually by the Department of Family Planning	Similar to above but with additional later information	Open distribution
	Pocketbook	Introduced in 1973 for annual production.		Open distribution
INDONESIA	**Monthly report**	Monthly from clinics based on their daily registers	Total number of new accepters by method; total number of repeat visits by method and reason for visit; activities outside family planning clinic: number of people contacted on home visits, number of referral cards distributed, number of group meetings.	Submitted by clinic in 5 copies: Central, provincial, regency, implementing agency, own files. Not later than fifth of following month.
	Regency monthly report	Based on IEC and training activities and personnel data	Reports IEC, training activities held in regency area. Logistics and personnel information also included. A special page provided for problems and suggested solutions.	Sent to provincial office by tenth of following month.
	Provincial quarterly report	Based on regency reports	Same as above. Summation of regencies' activities.	Sent to central level by fifteenth of month following end of quarter.

*Has accompanying write-up/interpretations.

Country	Name	Who produces? How often? From what?	Contents	Flow
INDONESIA (continued)	**Monthly project and finance reports (2 reports)**	Monthly by provincial office based on their accounts	Involves the financial situation of all projects under implementation as well as progress reporting	Sent to Bureau of Recording and Reporting by fifteenth of the following month.
	Monthly service statistics summary	Compiled by Bureau of Recording and Reporting from monthly clinic reports and flimsies (computer processed)	1st page: By province, number of registered clinics (by implementing agency), percentage of clinics reporting, number of new accepters that month by method plus cumulative performance indices 2nd page: Number of new accepters; revisits by methods; activities outside family planning clinics (field-worker activities). All by provinces.	Sent to provincial offices, central, implementing units and donor agencies. In addition, charts, ranking of clinics' reporting frequencies may also be appended.
	Summary quarterly report on accepter characteristics	Quarterly by the Bureau of Recording and Reporting. Based on 10 per cent sampling of flimsies	*Accepter characteristics, e.g., age, parity, method with provincial breakdowns. Example: April-October 1972 report covered age-parity trends. "Median age", "median parity" and" per cent in excess fertility group" were calculated for each province and compared by FY quarters. A graph was also presented.	Sent to provincial offices, central, implementing units and donor agencies.
	Technical report series	Special reports published by NFPCB and written by a variety of experts. Source of data depends upon the topic.	*Monograph 1: Indonesian National Family Planning Service Statistics *Monograph 2: Growth and Development of the Indonesian National Family Planning Programme Data System *Monograph 3: Indonesian National Family Planning Programmes: A Cost-Effectiveness Analysis *Monograph 4: Trends in Contraceptive Use: The Indonesian Experience *Monograph 5: Contraceptive Trends in Indonesia's Developing Family Planning Programme 1972/73 *Monograph 6: Age-parity Trends in the Indonesian National Family Planning Programme, 1971-1973	Open distribution which includes: — implementing units — provincial and central NFPCB staff — international donor agencies with family planning interests — other government staff with family planning-related activities — research and training institutions

*Has accompanying write-up/interpretations.

Country	Name	Who produces? How often? From what?	Contents	Flow
MALAYSIA	**Monthly NFPB clinic report** (varied format used by private doctors and estate clinics)	Monthly from clinics in programme based on the daily clinic records.	Information on clinic's activities: number of deliveries; abortions; staff members and clinic days per month; clinic hours and days: motivational and informational activities; accepters and revisits tally.	Sent to central office by the seventh of the following month.
	Missed appointment report	Monthly by NFPB clinics. Patients missing appointments are determined from filing of case cards by month of appointment (due after 3 months' grace)	Date of due appointment, and participant's IC number. Accepter by method accepted and date of acceptance; last visit by date and method accepted.	Same as above.
	Follow-up missed appointment report	Monthly, when appropriate; by clinic according to clients as they reappear to continue practice.	Patient's IC number; last appointment due; last visit date; last method accepted; date returned; current method; remarks.	If any follow-ups for missed appointments occur, this form is sent with other monthly returns to central office by the seventh of the following month.
	Active users report	Monthly report by all mobile and static clinics.	Case cards of all active accepters are counted. Provides tally of active users	Sent to Evaluation Division by first week of following month.

Country	Name	Who produces? How often? From what?	Contents	Flow
MALAYSIA (continued)	**Monthly statistical report**	Monthly from Evaluation Division based on clinic monthly reports.	Differentiated by clinics' implementing agencies: – number of accepters, provisional accepters, revisits and active users by state/clinic for month – number of monthly accepters by method – monthly cumulative accepter report – change in method from temporary to permanent – accepters of sterilization (male and female) by: . number of living children . age of wife . community . educational level . husband's occupation	Sent to all the main clinics and division head at the central level, participating agencies and other interested persons.
	Quarterly evaluation report (2 kinds)	Quarterly, by Evaluation Division based on clinics' monthly reports and Evaluation Division monthly reports.	Total accepters by state (by 11 accepter variables) Total accepters by ethnic group (by other variables) Total accepters by urban/rural areas Total accepters by total live children Total accepters by year of last birth, etc. Tables too numerous to list completely. * Supplement has short explanations; discussion of acceptance patterns; graphs of method achievements; discussion of integration programme; defaulter survey. In conjunction, a quarterly report of selected characteristics is sent to the 77 main clinics and others.	Sent to division heads, doctors, and those who can interpret the results (limited circulation).
	Annual report on evaluation	Annually by Evaluation Division.	Same as quarterly report but with annual coverage.	Same circulation as quarterly report.
	Evaluation series	From Evaluation Division; special reports; source of data depends upon topic.	* 1. Multiple acceptance report * 2. Evaluation summary of family planning performance by main clinics based on salary * 3. Ranking of coverage performance of NFPB clinics by state and district	Sent to division heads and the 77 main clinics.

* Has accompanying write-up/interpretations.

Country	Name	Who produces? How often? From what?	Contents	Flow
NEPAL	**Individual monthly report** (to be in full use by the end of 1973)	Monthly report completed by the field-worker from her diary, priority couple survey registration books, women's cards. 4 copies-field-worker, clinic, district, evaluation unit	1. Progress in area: number of vasectomies, condoms, loops in use 2. Current IUD and oral pill users, total vasectomies 3. Priority couple surveys conducted in the area. 4. Workload - input	Submitted for verification by a clinic staff member within 1 month after the reporting period. 2 copies are sent to the evaluation unit along with the clinic monthly reports, from the district offices.
	Centre monthly progress report	Monthly by centres based on client case cards, registers and field-worker reports	1. FP work progress (e.g., number of vasectomies, number of accepters by method) 2. MCH services (e.g., number of post-partum clients, number of smallpox vaccinations) 3. Mobile team report (e.g., number of days' work done, number of loops inserted) 4. Distribution of contraceptives to commercial outlets 5. Progress in education and publicity 6. Progress in centre areas by field-worker 7. Current FP use in area 8. Number of workers and input for month	
	Clinic summary report form	Produced by evaluation unit. Recorded monthly for a year. Based on centre monthly reports.	Two-way tables: rows are FP items, columns are months	Kept at evaluation unit
	Monthly and quarterly progress report	Evaluation unit's monthly report for each zone and district based on the summary report forms.	Annual target, month's target, month's progress, current FP progress and remarks for 20 items, e.g., number of new FP clinics to be opened; new/old post-partum cases number of health aides trained; number of mobile camps set up; communication activities; number of couples to receive FP service for the first time	Sent to the Ministries of Health, and Finance and the Educational and National Planning Commission

Country	Name	Who produces? How often? From what?	Contents	Flow
NEPAL (continued)	**Detailed FP report**	Evaluation section prepares this monthly on the basis of the two-way summary report forms.	Project, FPA and total achievements during month rendered by FP services (method-wise)	Sent to central sections, regional levels, FPA and USAID
	District-wise breakdown	Evaluation section prepares this monthly from district reportings.	Calculates score ratings by converting number of new accepters per method into sterilizations and then standardized by number of staff members. Second score rating from number of follow-ups done per staff member. Third score of number of couples covered in priority couple survey per staff member. Score ranges are 0-100. Average of 3 scores is taken. (Vasectomies are weighted)	Sent to regional and district levels; this is the only feedback available.
PHILIPPINES	**Clinic monthly summary report**	Completed by clinic monthly.	Number of personnel by staff category and hours spent in FP activities; status of supplies of contraceptives and record forms; summary of caseload.	Sent to NCC** monthly
	Monthly FP performance report	Computer output generated by NCC from monthly clinics reports.	Performance for the month of the entire programme arranged by participating institutions and compared to the previous month's performance. The performance for the month is further broken down by new accepters, return visits, total caseloads (new accepters' return visits), accepters by methods highest and lowest performing clinics and percentage of clinics reporting by institutions.	Sent to POPCOM, UPPI and other research institutions
	Monthly evaluation report	POPCOM produced based on the monthly computer outputs.	* Evaluation of monthly computer outputs, published for distribution to all participating institutions and other interested parties.	To participating institutions and other interested agencies

* Has accompanying write-up/interpretations.

** At present the computer work is being done at the POPCOM

Country	Name	Who produces? How often? From what?	Contents	Flow
PHILIPPINES (continued)	**Quarterly statistical** report (computer output)	Computer–generated report from NCC based on the 10 per cent sample of accepter flimsies.	Accomplishments in terms of number of accepters, return visits and meeting of target cumulative accepters for an institution during a particular reporting period. Distribution of accepters in terms of method and accepter characteristics.	Sent to POPCOM, UPPI and other organitions (USAID, etc.) 32 participating institutions and POPCOM receive this
	Institution performance report (computer output)	Computer–generated from NCC quarterly.		
	Clinic feedback	Computer–generated by NCC.	*Clinic performance in terms of accepters for the quarter and the clinic's standing or ranking within the institution and in the national programme.	Sent to all clinics
	Special reports	Computer–generated by NCC.	Statistical tabulation on accepters and clinic operations as may be required by POPCOM, UPPI and other research agencies	Sent to requesting parties
	Annual reports (there are two-FY and calendar year report)	From POPCOM	Summary of the programme's performance and accomplishments for the year	Participating agencies and other interested parties
REPUBLIC OF KOREA	**Monthly report**	Monthly from town/townships to health centres to province to central levels.	Pages 1 and 2: Personnel, registrations of accepters, IUDs, sterilizations, condoms distributed, oral pill (plus fee status) and IUD inventory. Information on these two pages are from data on page 3 received from the senior health centre workers.	Page 3 is completed by every town/township field-worker and every health centre worker once a month and sent to the senior health centre worker, by the first of the next month. Senior health centre worker then summarizes the data for the entire district and sends it to the provincial or metropolitan supervisory nurse by the fifth.

*Has accompanying write-up/interpretations.

Country	Name	Who produces? How often? From what?	Contents	Flow
REPUBLIC OF KOREA (continued)			Pages 1—2 are completed by the provincial or metropolitan FP supervisory nurse. Page 3: same as above except it is for the town/township or health centre levels only. Tabulated by the senior health centre worker.	Pages 1-2 are then completed at the provincial/metropolitan levels and sent to MHSA and KIFP by the fifteenth of the month.
	KIFP monthly report	From KIFP each month based on monthly reports.	*Cumulative achievement rates for the year against targets; contraceptive (IUD, pill, condom, sterilization achievement); status of field-workers (number authorized against number in position); field-worker activities; reaccepters; training; research and evaluation activities.	To be sent to provinces.
	Evaluation of national health center FP programme	From KIFP; covers a six-month period.	Analysis of service statistics (in Korean)	
SINGAPORE	**Weekly and monthly returns**	Monthly by evaluation unit from daily clinic records	New cases, revisits, total attendance by method by clinic and amount of money received	Reported to administrative levels and as (only) monthly feedback to clinics
	Monthly statistical report	Monthly by evaluation unit from monthly clinic returns, sterilization and abortion returns from hospitals and births from Statistics Department	New FP cases and revisits by method from 1966 to present; male counselling clinic attendance; sterilization (male and female); abortion by location from 1966 to present; live births in Singapore 1966 to present	Reported to administrative levels
	Monthly returns of social welfare cases	Monthly, by evaluation unit from clinic returns	New and revisit cases by method	Reported to administrative levels
	Monthly returns of depo-provera	Monthly, by evaluation unit from clinic returns	New and revisit accepters (by number of injections) for each clinic; mainly for clinical purposes	To senior health officer of MCH
	Monthly summary of IUD	Monthly by evaluation unit from clinic returns	Total new insertions, reinsertions, removals, expulsions, complications and pregnancies by age, parity and clinic; mainly for clinical purposes	To senior health officer of MCH

*Has accompanying write-up/inter pretations.

Country	Name	Who produces? How often? From what?	Contents	Flow
SINGAPORE (continued)	**Monthly home sales**	Monthly, from clinic returns	Number of home sales of pills/condoms by clinic	To administrative levels
	MCH quarterly report	Senior health officer in charge of MCH prepares it from the monthly clinic returns	MCH activities; FP information includes number of new cases, revisits to clinic, number of home visits by different staff categories to clinic/post-partum contact service defaulters	Sent to Deputy Director of Medical Services (Health) and Public Health Matron
	Monthly tabulations	From front and back pages of the client record form by the evaluation unit's team	Method prescribed by citizenship, social welfare case, age, contraceptive history, reason for FP, ethnic group, number of living children, by clinic. Revisits by method in use and clinic, whether routine supply by nurse or results of checks and new method prescribed	To chairman of FPPB (same as DDMS) and Executive Secretary
	Quarterly bulletin	Summary extract from monthly bulletins	* Same as above but in lesser detail	To administrative levels
	Annual report	From front page of clinic card by evaluation unit	New accepters by age, reason for FP, education, ethnic group, number of living children, employment, method prescribed, most recent method used, duration of marriage	To administrative levels and clinics
	Special reports: Follow-up study Reports on the oral pill and injectables	FP and Population Board staff and statisticians of the Public Health Division	Continuation rates for oral contraceptives Clinical study for the injectables	Open distribution
	Cost-effectiveness analysis	Same as follow-up study	Covers period from July 1967 to December 1970. Calculates cost to prevent one birth by various methods.	

*Has accompanying write-up/interpretations.

Country	Name	Who produces? How often? From what?	Contents	Flow
SRI LANKA	**Monthly statistical returns: (1) Monthly record of FP work by the clinic**	Completed monthly by the clinic medical officer from clinic cards and IUD/sterilization registers	Lists each client by ID number according to date she/he attended; contraceptive services rendered (amount distributed in case of condom, pill, IUDs, sterilizations-male/female); data on age, number of living children and age of last child are collected for new accepters only.	3 copies sent: 1. Medical officer of health by the fifth of each month 2. Medical statistician by the fifth of the next month 3. One for file
	(2) Monthly statement of FP work by PH field staff	Completed by PH midwives and PH inspectors each month from client cards	Same as above plus: – Number referred for loop insertion (instead of loop inserted data) by whether it was inserted or not – Number referred for sterilization (instead of actual count)	Two copies sent to medical officer of health, one copy for file. (Medical officer of health forwards one copy to the medical statistician)
	Consolidated statement of medical officer of health on FP work	Filled out monthly by MOH; based upon the monthly returns he receives	Clinic/hospital area of midwife by: Condoms – number of persons, quantities distributed for old/new cases Foam tablets – number of mothers, quantities distributed for old/new cases Oral pills – same as foam IUD – number inserted, removed or expelled Sterilization – number of males/females Number of mothers conceiving	Sent to division's heads (also known as superintendents of health services) and to the Medical Statistician (by the tenth of the following month)
	FP feedback report on new accepters by Superintendent of Health Services (SHS) area	Prepared monthly by the Office of the Medical Statistician from monthly statistical returns	*New accepters reported for month by end of following month Percentage of monthly target achieved Cumulative new accepters for year percentage of year's target achieved	Sent to 15 superintendents of health services and 98 medical officers of health as well as other decision-making officers

*Has accompanying write-up/interpretations.

Country	Name	Who produces? How often? From what?	Contents	Flow
SRI LANKA (continued)	**Quarterly report on new accepters of FP**	Same as above but with quarterly coverage	* New accepters by methods; precise tables with cumulative indices, e.g., acceptance rates per 10,000 population by SHS areas for year; age-specific acceptance rates for married women; accepter characteristics also analysed (age of client, age of last living child and number of living children); changes in pattern of contraceptive acceptance.	Sent to 15 superintendents of health services and 98 medical officers of health
	Annual report on new accepters of FP Follow-up survey reports are available for loop, oral pill, and also a field-work survey report	Same format as quarterly report		

*Has accompanying write-up/interpretations.

Country	Name	Who produces? How often? From what?	Contents	Flow
THAILAND	**Monthly activity report**	Prepared monthly at district health offices from the daily activity records for only the service units without doctors. All other service units complete this themselves.	Number of new accepters for month by method; number of revisits by IUD, pill or other methods; number of home visits by post-partum, accepter/other reason; cycles of pills distributed to new/old accepters	Sent to research evaluation unit and to Provincial Medical and Health Services Office (PMHSO); evaluation unit should receive reports by fifteenth of next month. * PMHSO uses its copy to prepare a comprehensive monthly report of all health services which it sends to the Ministry of Public Health.
	Monthly accepter report (called monthly report on FP accepters)	Prepared by evaluation unit monthly from monthly reports. Time lag is about 2 months from receipt of original data.	Number of accepters for month by method; cumulative number by method. Above are broken down by organization, region, provinces.	Mailed to all reporting, administrative and service units of NFPP (except for centres without doctors) and other interested parties
	Semi-annual and annual reports: Compiled from monthly accepters reports but also include information on research and evaluation, training, communications, administration, supply, etc.			

* Has accompanying write-up/interpretations.

Country	Name	Who produces? How often? From what?	Contents	Flow
THAILAND (continued)	**Pill distribution report**	Monthly from the evaluation unit based on distribution information included in monthly activity reports	Summarizes the number of pill cycles distributed to new and old accepters broken down by organization, province and district. Number of units submitting reports is also specified.	Retained at NFPP head-quarters with limited distribution
	Accepter analysis	Periodic reports on accepter characteristics are prepared by the research and evaluation unit from a 1:60 sampling of the flimsies Flimsies also used as a frame for selecting a national probability sample for follow-up surveys	First report (May 1971) examined age at acceptance, residence, husband's occupation, number of living children, desire for more children and the open-birth interval.	

ANNEX X

DATA AVAILABLE FOR INPUT-OUTPUT ANALYSES

Inputs: Staff (S)
Clinic (C)
IEC
Training (T)
Supplies/equipment (S/E)

Outputs: Client characteristics (CC)
FP services (FP)
MCH services (MCH)
Follow-up client data (F)

Country	Input data	Output data	Input/output ratios used	Other performance indices tabulated
FIJI	IEC: –FP education activities –Health education activities (activity information not usually given in terms of hours spent)	CC: — Race only FP: — Caseloads — Methods chosen by first attenders — Estimated number of women currently "protected" by each method — Revenue from contraceptive sales — Commercial contraceptive sales MCH: — Patient loads — Ante-natal first visits — Public health measures taken — Number and type of immunizations given	None	Percentage protected Estimated number of women currently "protected" divided by the estimated number of women aged 15-44 calculated for contraceptive methods and area divisions

Country	Input data	Output data	Input/output ratios used	Other performance indices tabulated
HONG KONG	C: –Total number of clinics –Total number of sessions S: –Individual welfare worker performance: Number of contacts made Number of referral slips issued Number of working sessions Number of travelling hours spent in each type of activity –Source of referral	CC: — Visit status plus core information (age, parity, etc.) FP: — New, old cases, revisits, total attendance — IUD insertions, oral (new) clients, new injections, sterilization applicants — New cases since beginning of year and two years ago (all above classified by clinic location and sex of clients. Subfertility totals married life information) — New cases by clinic by method — reason for not returning to clinic — IUD complications	Average attendance per clinic hour Welfare worker's performance ranked by: Number of slips issued per working session Number of slips returned per working session Number of slips returned	Acceptance rates (1961–1969) Analysed by age, parity, education and husband's occupation

Country	Input data	Output data	Input/output ratios used	Other performance indices tabulated
INDIA	S: — Number of posts required/sanctioned/in position per of those *de facto* in position and number trained in FP IEC: — Community education activities held during a particular month as well as cumulative figures T: — Regular/special training courses by staff category — Orientation training for the staff in full or part-time FP work S/E: — Equipment and transport items' descriptions by number required/sanctioned/in working order	CC: — Sterilization cases by sex, rural-urban location of clinic FP: — Number of sterilizations and IUD insertions done at centres, camps, mobile units (by implementing agency) — Contraceptive distributions (condom, jelly/cream/foam) at depot holders, private medical practitioners, centres, etc.	Cost per equivalent sterilization calculated routinely. Special studies one involving a linear regression model and the other a case study approach, are available that gauge programme performance. Many cost-benefit analyses were done which measure – The value of an averted birth, – The impact of birth prevention on *per capita* income; and – Cost-benefit ratio (computed from averted birth value) Other studies on cost-benefit ratios and cost-effectiveness by Seal (1971, 1972) and Bhatnagar (1972)	(1) Cumulative performance up to particular month compared to corresponding period of previous year by method (2) Index of proportionate target achieved by methods (3) Contraceptors per 1000 population by method (4) Percentage of couples "protected" (5) Number of births averted in various years (6) Inputs: "in position" is compared to "sanctioned positions" as well as consideration of required inputs

Country	Input data	Output data	Input/output ratios used	Other performance indices tabulated
INDONESIA	S: – Field-workers' activities: – Distribution of referral cards – Number of household contacts – Referral source C: – Number of clinic sessions – Number of clinics reporting each month IEC: – Number of group meetings – Number of persons attending	CC: — Core variables plus status of visit and reason for visit FP: — Methods accepted — Complications — Supplies distributed	Cost-effectiveness analysis; numerators: Government of Indonesia and foreign donor obligations for 1968-1973 (in $US). Denominators: — Number of accepters through FP programme by method — Total population of Java and Bali — Estimated fertile women aged 15-44 (Java and Bali) — Couple-years of protection (CYP) — Clients served (1970-1973) Indices: cost per: capita fertile woman accepter CYP client served	(1) Cumulative acceptance achievement as proportion of target (2) Cumulative new accepters per 1,000 fertile women (3) Ranking of reporting clinics Above are tabulated by provinces and regencies.

Country	Input data	Output data	Input/output ratios used	Other performance indices tabulated
MALAYSIA	S: — Number of staff — Source of referral — Number of contacts made by worker C: — Number of clinic days per month — Clinic hours and days IEC: — Number of sessions and number of persons attending wards and health centres — Number of group meetings held and number attending T: — Number of trainees completing courses S/E: — Supplies requested, on-hand and distributed — Commercial sales	CC: — Accepters' visit statuses (provisional, transfers, etc.) — Multiple acceptance registered — Core variables FP: — Number of deliveries and abortions within the locality — Methods serviced — Cumulative accepters by method — Number of active users, number of provisional accepters	(1) FP performance by clinics — Combined weighted output (accepter-type weighted by recruitment time or servicing time) — Basic salary cost per accepter — Basic salary cost unit combined weighted output (total annual basic salaries of clinic staff divided by annual combined weighted output for that staff) (2) Training programme effectiveness — Cost-effectiveness in terms of Man-years of FP services rendered Expenditures incurred CYPs Births averted (3) IEC programme effectiveness — Performance of information staff (man-hours of services rendered, contents of messages delivered) — Cost-effectiveness (same indices as for training programme)	(1) Multiple acceptance rates (2) Ranking of coverage performance of clinics Clinics (by area) are ranked according to their performance in regard to the following rates: — Rate of accepters — „ „ provisional — „ „ revisits — „ „ continuing users All standardized per 1,000 eligible women
NEPAL	Individual field-worker S: — Number of couples surveyed for priority couple survey			

Country	Input data	Output data	Input/output ratios used	Other performance indices tabulated
NEPAL (continued)	— Number of couples mottivated — Number of days worked per month within and outside area Mobile team — Number of days worked by staff category — Number of vasectomies done, and IUDs inserted Clinic — Number of paramedical workers — Number of days of work for each staff category C: — Number of days of field-work done under clinic (number of clinic hours not reported systematically, but known) IEC: — Number of community education activities — Number of days above was done by Family Planning Organization (FPO) — number of posters, pamphlets, films, slides, display boards presented T: — Number of FPO seminars — Number of health aides trained (new and refreshers) S/E: — Number of record forms needed each month (for replenishment) — Amount of supplies distributed, received and balance	CC: — Accepter characteristics, maternal history details collected in more detail FP: — Methods serviced — Transfer clients — Camp/mobile team activities and accepters recruited — Priority couple survey MCH: — Number of new/old pregnant mothers — Post-partum treatees — Infants, toddlers small pox, BCG, DPT immunizations F: — Number of follow-ups done	(1) Achievement per staff (in terms of equivalent sterilization) (2) Follow-ups done per staff (3) Priority couples surveyed per staff (field-workers rate couples visited at home according to their need for FP = priority couple) Average is taken of above 3 scores for each district, and performance is compared.	Ratios of FP and MCH targets against achievements are tabulated monthly by area.

Country	Input data	Output data	Input/output ratios used	Other performance indices tabulated	
PHILIPPINES	S: — Number employed and number of hours worked during month — Number of staff member in each position, employing agency, part-or full-time basis, incentives C: — Clinic background — Period open for FP services (hours/week); number of hours clinic was open for FP during month — Clinic area (square meters) IEC: — Source of information T: — Training undergone by each member (where, what kind, how long) S E: — Contraceptive supplies received, dispensed and balance — Record form supply and business-reply envelope supply — equipment: item, quantity, unit cost, total cost source	CC: — Usual core information — Acceptance status — Motivation to accept FP: — Total number of clinic visits by client's status, methods serviced — Number of coupons credited to motivators (paid on an incentive basis) — Number of flimsies sent to FP data centre — Caseload MCH:— Post-partum and antenatal services rendered (only for integrated clinics) F: — Field-worker's follow-up of "delinquent" clients		(1) Accepters per month by clinic, implementing agency and entire programme (clinics are ranked) (2) Caseload per month by same as above (3) Number of accepters per 1,000 eligible women for each city/province and entire programme (4) Clinic density in area, programme (number of eligible women per clinic)	-
REPUBLIC OF KOREA	S: — Personnel authorized *versus* those currently employed — Background education, experience and training received — Referral source IEC: — Number of health education activities S/E: — Supply (contraceptive) distribution and inventory (and fee charges)	CC: — Core variables reported on coupon FP: — Methods serviced for accepters	Achievement per field-worker —Number of accepters per worker (by method) —Number of consultations —Cost-benefit study under way at present	Cumulative achievement rates by method Percentage of target achieved by method	Supply/equipment: Data also available on Planned Parenthood Federation of Korea operations as well as its clinic operations data

Country	Input data	Output data	Input/output ratios used	Other performance indices tabulated
SINGAPORE	S: — Total number of home visits made — Total number of clinic referrals by post-partum contact service — Source of referral C: — Total number of clinics — Total number of sessions S/E: — Contraceptives requested, dispensed and balance	CC: — Usual core information motivation to accept (source) — More details for abortion and sterilization clients FP: — Methods serviced — Record of fee charges — Visit status — Abortions and sterilizations by location — Cytology — IUD complications	Cost-effect analysis done on national programme for period July 1967 to December 1970 by Mr. Wan Fook Kee and Mr. Quah Siam Tee. Comparative costs to prevent one birth by contraceptive methods have been computed.	
SRI LANKA	S/E: — Contraceptive supplies received, dispensed and balance Unused training capacity is known to the Family Planning Health Bureau	CC: — A few core information — Revisit and acceptance status FP: — Methods serviced, fee charged for contraceptives MCH:—Number of mothers who gave birth	Has not been done	To make a comparison among the 98 health areas and the 15 health divisions, the number of new accepters per 10,000 population is calculated for each.

Country	Input data	Output data	Input/output ratios used	Other performance indices tabulated
THAILAND	Details not regularly reported but input data are available: S: — Personnel records kept (whether records on hours spent are kept was not specified) — Positions approved/sanctioned — Number of home visits IEC: — Materials produced — Communication media operations T: — Type and length of training records (location also) are available S/E: — Contraceptive supplies in/out flow (maintained through Medical Supply Section)	CC: — Core information — Acceptance status FP: — Methods serviced — Number of post-partum clients F: — Number of follow-ups	(1) Cost per accepter (2) Cost per woman-year of protection has been calculated in separate studies	Effectiveness studies currently under way (and proposed) to assess role of midwife, IEC programme, clinics.

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